## **VOID**

# CERTIFICATE #

2008 - 08001

SEE

CERTIFICATE #

2007 - 43675

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death

Physician
/Medical
Examiner

**Funeral** Director

"natural", or Items 23a or 28a-f show dieal Examiner must be notified at permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natur any injury or other traumatic event, the Medical once.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

law requires that the death certificate be executed burial physician s the burial attending p for use as signed by the a Id be detached f cate has l certificate After this c To the Hospital or Attending

Division or Vital Records, P.O. Box 68760,

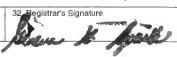
within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

08002 1. Decedent's Name (First, Middle, Last) Month Dav Shirley K1enke March 11 2008 12:12p 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Fairhaven Carrol1 Sykesville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 055-14-2148 1919 May 21 NJ Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Carrol1 Sykesville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7200 Third Avenue 21784 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√☐ No Specify: Specify: white þ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) banking banking administration 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Willard Hunt Clara Rieger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Weisse (attorney) 212 Pennsylvania Ave., Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, MD All County Cremation 3-12-08 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHaight Funeral Home & Chapel Daignalaiget aferbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stage Pulmonary Fibrosi disease or condition resulting in death) Due to (or as a con equence of): distructive Pulmonary discare Chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à GISCUSC artery COLOVORA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 ☐ Yes No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပို Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 2 Accident (Month, Day Year) 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Doordord 3/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ana Surante M.D. 7200 Third Ave., Sykesville, MD 21784

31. Date filed (Month, Day, Year) State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Mwangi Karangu <u>2008</u> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3144 Mavenwood Avenue <del>حال</del>بسهده Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) Sex 1 ☐ M 2 ☐ F **Funeral** Days Months Hours 058-36-1714 9.15.1932 Kenya Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any lijury or other traumatic event, the Medical Examiner must he matting once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ¥es 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21213 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 THO 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 L If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Completed by Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Murgan State University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) ဥ Wamb Karangu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3144 Mavenusod Ave Baltimore, MJ 21213 Karangu 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/22/2008 Kangema Kenya 4 Donation 5 Dother (Specify) angema Muranga! 22. Name and Address of Facility Vagon C. Oreeno Fureral Services 21. Signature of Funeral Service Licenses 4905 York And Baltimore, MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Renal Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Diobete Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner law requires that the death certificate be executed Due to (or as a consequence of): attending physician and for use as the burial-tra resulting in death) Last Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Onknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform certificate Division or Vital 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Yes 2 | No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Medical Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number

Blvd

045876

Ball-more MD 21236

29d. Date signed (Month, Day, Year) 08

and manner stated.

4920 Campbell

2. Registrar's Signature

wasmo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician MARCH Year Annie Mozelle Leake 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MOR N/A Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Months Days Hours Min 246-38-6339 87 Director 26, 1920 N.Carolina Nov. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Baltimore Director Catonsville 1 ☐ Yes 2 TXO Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 4832 Grand Bend Funeral Drive
Was Decedent Ever in U.S.
Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. Specify: Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Child Care Provider permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If Item 27 Is marked other the any Injury or other trainmant. Private family 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Raymond Craven Anna Rogers 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Jackson/Daughter 4832 Grand Bend Drive Catonsville, Md 21228

Oa. Method of Disposition (Name of Job, Place of Disposition (Name of Job, Place of Disposition (Name of Job)

Oct. Location - City or Town, State Western Star Cemetery 12/03 Purial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, Maryland 21. Signature of Funeral Service Line 22. Name and Address of Facility Chathan Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, such, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to finine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a cons The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 | Yes 2 □ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed certificate 21 No 1□ Yes Division or Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ျှ 1 Tes Inpatient 2 ER/Outpatient 3 DOA this 27. Ma or of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Daté signed (Month, Day, Year) 3 ted cause of death (Item 23a) (Type, Print ENT 202 W. M Name and address of person who comple PLE RD, LINTHICUM, MD

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deatl Year **Physician** Imelda C. Langley March 6, 2008 10:45 AM<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Timonium Baltimore 8. Date of Birth (Month, Day, Year)
June 20, 1933 5. Social Security Number f Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 6. Sex 7. Age (In vrs. last birthday **Funeral** Hours Days 1 □ M 2 😾 F 74 Director 124-28-4918 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits at a or 28a-f shot be notified a 1 ☐ Yes 2 ☐ No Director MD Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 2-B Beehive Place 21030 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify white Specify: 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygier fitem 27 is marked other the r other traumatic event, the secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James J. Cunningham ဥ Agnes T. Lightcap 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew Bailey/son 17 Milstone Road Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If its any injury or o once, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Euneral Sprace Licensee Ronal S. Wade. Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MĎ 21201 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NODULAR MINTHS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the bunial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year 4□Pregnant at time of death 5 Other (specify) is certificate has been signed by the director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣ Unknown Completed 24a. Was an autopsy performed? 1□ Yes 2 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HDSP(LE-Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28b. Time of

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, funeral After t death. 24 hours after deatl Funeral Director: filled in by

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier (Check only one)

Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

164395

29d. Date signed (Month, Day, Year) MARCH 6.2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 NOMBRUS ST, SMITE 209 BALTIMONE MO, 21204 DANIEUE DOBERMAN, MO 31. Date filed (Month; Day, Year)

State Registrar

completely

within 24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🔓 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 8,2008 Month Francis Ρ. Levden March 6:57 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6924 Gateway Blvd District Heights Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Date of Birth (Month, Day, Year Sept 23, 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days Year) 015 18 7121 85 1922 Mass Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Maryland Prince George's District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6924 Gateway Blvd 20747 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. MYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 Oceanographier Coast Guard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martin Leyden Thecla (unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip CodeROQ10 Virginia Leyden (Ex Wife) 411 Lakewood Circle Apt 804, Colorado Springs, Co 20b. Place of Disposition (Name of cemetery, crematory or other place) March P1te, 2008 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD Lee Cremation Crematory 21. Signature Funeral Service Licenses 22. Name and Address of Facili Lee Funeral Home,Inc 6633 01d Alexandria Ferry Road, Clinton, MD Approximate Interval Between Onset and Death ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ire. List only one cause on each line. Immediate ause ardio-Pulmonar disease or condition resulting in death Due to (or as a consequence of): 01,00 year 23d. Date of delivery 4☐Pregnant at time of death 9☐Unknown 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

burial-tran

Completed by

Medical Certification: To Be

page 2

funeral

requires that the death certificate be executed

Physician;

Hospital or Attending

within 24 hours after deatl To the Funeral Director:

Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

"natural", or Items 23a or dical Examiner must be I

the Medical

s 1 and 2 should be filed if the alth and Mental Hygin them 27 is marked other other traumatic event, the

i. Pages 1 and 2 surfament of Health ar strant: if item 27 is 1-1, irv or other trr

Important: It any Injury o

Director

Funeral

Completed by

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P

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Saltimore, Maryland 21215-0036

dical Examiner	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  c. Hypertex 5: ~  Due to (or as a consequence of):  d	ari
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	
급	Port II Other elemitional condition	one contributing to death but not reculting in the underlying cause given in Rest I	20

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 📉 No 3 Probably 4 Unknown

24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 2 No autopsy performed 2 X No 26. Place of Death (Check only one)

	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	
1	27. Manner of Death  1 ☒ Natural 5 ☐ Pending	

2 ER/Outpatient 3□ DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work?

investigation 2 ☐ Accident 6 Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

SAIE

MAR 1 2 2008

31. Date filed (Month, Day, Year)

0051 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

13-10-2000

State Registrar

6400 Manlboro Pike, Distvid 32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month Frances Lee 9:00 A M March 10, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death <u>11630 Glen Arm Road apt U 22</u> Baltimore Glen Arm Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days 4/28/1920 1 ☐ M 2 ☑ F Hours Min. Maryland 215-42-6654 87 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Glen Arm 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11630 Glen Arm Road 21057 USA Apt U 22 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edgar Piersol Mary Elizabeth Guthrie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Lee Edington / Daughter 13 Devon Hill Unit C2 Baltimore, MD 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State tx Burial 2 ☐ Cremation 3 ☐ Removal from State Fairview Meth Cem. Phoenix, Maryland 4 □ Donation 5 □ Other (Specify) 3/14/2008 Towson, Maryland 21204 21. Signature of Funeral Bervice Lie 22. Name and Address of Facility 1elle Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that cause 11th death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death)

Physician /Medical Examiner

ng physician and as the burial-transit

attending | for use as

cate has been signed by the a , page 2 should be detached f

certificate has

eral Director: After this certific filled in by the funeral director,

death.

To the Hospital within 24 hours a

To the Funeral I

completely filled

i Director:

or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Frances Lee Division or Vital Records,

Examine

Physician/Medical

<u>م</u>

Completed

Be

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Certification:

Medical

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

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Completed

10a. State

MD

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a	original	e Heart
	Due to (ot as a consequer	nce of):
b. –	Hyperte	asion
	Due to (or as a consequer	nce of):
c	atrial	Fiferillat
	Due to (or as a consequer	nce of):

23b. Was decedent pregnant in the past 10 menths? 9 Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death 9☐Unknown

3 ☐ Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

scleivsis

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner' 1 Yes No 27. Manner of Death

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

and manner stated.

Other: 4 Nursing Home S Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3∏ Suicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? M 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

4 Homicide

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and file of certifier

29c. License number D3643 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print MASSARI

HER MILL 3346

State Registrar

31. Date filed (Month, Day, Year)



C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 24, 2008 9:00 PM M February Joseph Larue 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Harford Havre de Grace Harford Memorial Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 unk 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 1⊠M 2□F Days Hours 70 213-36-7784 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County 1 ☐ Yes 2 ☐ No Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 869 Ohio Street 21078 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married unk 1 ☐ Yes 2 No Specify: Specify: black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry unk College (1-4or 5+) Elementary/Secondary (0-12) unk 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harford Memorial Hospital 501 S. Union Avenue Havre de Grace, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☑Other (Specify) in state State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Approximate Interval Between Onset and Death nt 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ack, or heart failure. List only one cause on each line. HYPOTUERMIA Immediate Cause (Final ACCIDENTAL disease or condition resulting in death) Due to (or as a consequence of): INFARCTUN MYO CARDIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a cons 1. YUKNA, MD, DEPUTY MEDICAL EXAMINER BERNARD DO014201 2-26-08 23d. Date of delivery ctopic pregnancy Month Day Year Other (specify) 23e. Did tobacco use contribute to the cause of death? lerlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

permit. Pages 1 end 2
Department of Health an Important: if item 27 is reeny injury or other-**Physician** /Medical Examiner Examine

**Physician** 

/Medical

Examiner

**Funeral** 

Director

item 27 is marked other then "naturel", or items 23s or 28s-1 show other traumstic event, the Madical Examiner must be nutitled at

and Mental Hygiene.

B la

Baltimore, Maryland 21215-0036

Completed by Funeral Director

Be

unk

attending physicien end for use as the burial-transit sete has been signed by page 2 should be detacl or Attending Director: filled in by within 24 hours a To the Funeral C

Certification; To Be Completed by Physician/Medical

Medical

29a. Certifier

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 🗆 E
Part II. Other significant condition	s contributing to death but not resulting in	the unc
25. Was case referred to medical examiner?		
1 Yes 2 No	Hospital: 1 Surpatient 2 ER/Out	patient
27. Manner of Death	28a. Date of Injury 28b. Ti	

					24a. Was an autopsy performed?
se referred to medical				26. Place of Death	Check only on
er? s 2□No	Hospital:	2 ☐ EB/Outpatient	3 🗆 DOA	Other:	a 5 Pasidence

Yes :	2 □ No	nospitar. 1 Supatient 2	☐ ER/Outpatient 3☐ !	DOA Uner: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (	Specify)
Manner of D Natural Accide	5 ☐ Pending investigation	$\alpha$	28b. Time of Injury  /057 AM	28c. Injury at Work? 1 ☐ Yes 2 ☑ No	28d. Describe how injury occurred HYPOTHER MIC	COLD
3 🔲 Suicide	6 ☐ Could not b	e 28e Place of Injury - At I	nome farm street fact	ony office	28f. Location (Street and Number of	or Rural Route Number,

3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
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🔀 Certifying Physician: To the best of my knowledge, death occur

				HAVRE			
rred at the time, date and pla	ce, and due	e to the cau	use(s) and	d manner as	state to the	d. 2107 e cause(s)	8

ENVIRONMENT

(Check only one)	2 Medical Examiner: On the basis of examination and/or invalid manner stated.
29b. Signature and	d TNe of certifier

estigation, in my opinion, death occurred at the tim	e, date and place, and due to the cause(s)
29c. License number	29d. Date signed (Month, Day, Year)
2 25-1 201	2-25-2002

				Da 07	6216	12-63	2000
30. Name	e and address	f person who completed cause of	of death (Item 23a) (Type, Print)		. 1		
JAS	SON B	IRNDAUM MO	501 S. UNION	Ave	Haure de	GRACE, MO	2107

State Registrar

MAR 1 2 2008

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year Maxine Lewi 1740 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore NA UMMS If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 1□M 2**V**F 55 217-62-1506 epT. 27, 1952 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD HANOVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21076 GESNA U.S.A Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 M No 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales RETAIL MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JACK OWENS LAVERA TEX RIA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHILIP 1429 GESNA Drive MD LEWIS- HUSBAND HANOVER 21076 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 3-14-08 ARBUTUS MEM 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service dicenses Name and Address of Facility
Michael Ziglier Funeral Service, P.A.
3512 Frederick Ave., Balto. MD. MD, 21229 23a. Part1. Enter the disease, or come datibles that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the choice on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) erebras Due to (or as a consequence of): 4 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last lung Cmonths `a Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed res 2 1∐ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 3□ DOA 2 ER/Outpatient 28c. Injury at Work? 28d. Describe how injury occurred

Examiner and requires that the death certificate be execu Box 68760, attending physician for use as the buria P.O. the been signed by Division or Vital Records, this certificate has

After t

filled in by

**Physician** 

/Medical

Examiner Physician/Medical Completed director, page 2 : Be P funeral Certification:

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

B

Funeral

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

25. Was case referred to medical examiner? 1 ☐ Yes 27. Manner of Death 2 Accident 3 ☐ Suicide

4 ☐ Homicide

29a. Certifier (Check only one)

To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Medical

> State Registrar

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Green St.

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number NPI: 1821206673

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22

GIDSON een 31. Date filed (Month, Day, Year)

2008

32. Registrar's Signatus

08-01692

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Edith A. Martini State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar Decedent's Name (First, Middle Last) 2. Date of Death Physician/ Month Day February 28, 2008 0949 hrs **Medical Examiner** Edith A. Martini c. County of Death 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death **Baltimore County** Franklin Square Hospital ESSEX 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Funeral 2 X Apr 14, 1941 Months Days Hours Min 66 Country) Vi<u>rginia</u> Director 219-38-8448 М Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County or 28a-f show 1 Yes 2 X No Baltimore MD Essex must be notified at once. death with the Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 744 Sue Grove Road 21221 IISA 듑 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X Married Never Married Yes 2 X No permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o injury or other traumatic event, the Medical Examiner in Divorced If Yes, Give Year 3 Widowed 1 Yes 2 X No specify: Specify: white ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 0 flowers florist 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Beulah Brown Marvin Rose 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 744 Sue Grove Road Essex, MD 21221 Bobby Martini/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 4 X Donation 5 Other Specify 21. Signature of Funer | Service Licensee | Wade, State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Methadone, oxycodone and alcohol intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical XUNPENDED AMENDED Ttems e attending physician for use as the burial 23a27 & 28a-f per MFO G-877 3/13/08 reb Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknowr by the a Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? certificate | ✓ Yes 2 No 1 V Yes 2 Nο Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this 1 🗸 Yes 28a. Date of Injury (Month, Day,Year) After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: n 24 hours after death.

le Funeral Director: A
letely filled in by the fil 1 Natural Yes 2 X No Unknown Director: d in by the f Pending 2/28/08 found found 8:50 a 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) /44 Sue Grove Rd. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide (Specify) found at home Homicide 29a. Certifier 1 [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 29, 2008 oma Mi incenti, mis 30. Name and address of person who completed cause of death (Item 23a)

State Registra

DHMH 17 Rev 1/2001

OCME 2006

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

WELLE A

32 Registrar's Signature

2008

Donna M. Vincenti, MD

31. Date filed (Month, Day, Year)

### Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3 Time of Death Month Dey Physician 9, Gloria Dickson Martin March 2008 9:00pm /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Transitions Healthcare Sykesville Carroll If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country)
 L 7. Age (In yrs. last birthdey) Funeral 8. Date of Birth (Month, Dey, Year, Days 1□M **2**√□F Months 83 Yrs Director 219-18-7793 Sep 11, Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location show 10d. Inside City Limits Item 27 is marked other than "natural, or items 23e or 28e-f sho other traumstic event, the Medical Examiner must be notified at 11 Yes 2 No Funeral Director MC Anner Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 213 Somerset Bay Drive #302 21061 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 ☐ Yes 2 1 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Homemaker Domestic 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Health and Mental Walter Darrell Martin Minnie Bourland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Darrell Martin (Daughter) 777 San Antonio Road #50, Palo Alto, CA 94303 Department of Hear important: If Item any Interest 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-13-08Powell Cemetery Fair Bluff, NC 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, P.A. 21. Signature of Funeral Service Licensee Har MO0764 Box 195, Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) men Examiner Due to (or es a consequence of) Examiner The law requires that the deeth certificate be executed signed by the attending physicien and d be detached for use es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown ð pege 2 should be 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy been completion of cause of deeth? this certificate has 2 No 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: filled in by tha funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 2 1 Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) Certification: 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Director: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours e To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner steted. 29a. Certifier Medical completaly (Check only one) 29b. Signature and title of confifier 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Kus Stone 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature, State 2008 Registrar

**DHMH 16 Rev 6/95** 

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2008 Month **Physician** March 9, 9:50 A.M Hilda Elizabeth Marshall /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10008 Lyons Mill Road **Baltimore** Owinas Mills 8. Date of Birth (Month, Day, May 9, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2XX 96 Hours Maryland Director 212-01-9336 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show irai", or items 23a or 28a-f shov Examiner must be notified at 1 TYes XXNo Director Maryland Baltimore Owings Mills 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code death with 10008 Lyons Mill Road 21117 of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or itea any or other traumatic event, the Medical Examines. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽŽNo Specify Specify: Completed by ₩idowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8th College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irving Myers Myrtle Ensor ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Magee (Daughter) 2402 Alpine Court, Finksburg, Maryland 21048 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evergreen Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State March 12, permit. Pages Department of Important: If It any injury or o once, 1 Cremation 3 Removal from State 4 □ Donation 5 □ O(ther (Specify) 2008 Finksburg, Maryland S nature of Fune 1 Parviol Lice Eckhardt Funeral Chapel, P.A. nain 11605 Reisterstown Road, Owings Mills, MD 21117 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, social cardialure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician dise se or condition resulting in death) e tive Due to (or as a consequence of): /Medical Examiner Due t (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed and the burial-tran Marke Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by een signe hould be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of page 2 certifica e has autopsy performed he death? 1 ☐ Yes 2 No 201Nn or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 ™o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 29a, Certifier 1, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

completely

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.a

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND FIEWED per FH (877.3/28/08 WS)
State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 03-09-2008 12:40 PM Darlene H. Majeski /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death **Examiner** Harford 404 Hemingway Dr Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04-18-1945 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Days Hours 1 ☐ M 2 💢 F 040-36-6562 62 Conn. Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 404 Hemingway Dr 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) APG Secretary 17. Father's Name (First Middle 12st) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental F Helen Nitsche Charles Majeski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 and 2 bepartment of Health ar Important: If Item 27 Is any Injury or other trau 404 Hemingway Dr Bel Air, MD 21014 John D. Majeski (Husband) Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Mem. Gardens | 03-13-2008 | Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Berein a. Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mos /Medical Examiner 7 mos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed and as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy atter for u in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has autopsy performed? 1 Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To ÷ L funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No neral Director: A 2 Accident 6 Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ö within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Jara 10, 2008 State Registrar

DHMH 17 Rev 1/2001

Registrar

State

31. Date filed (Month, Day, Year)

MAR 1 2 2008

32. Registrar's Signatury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 2 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 03/10/2008 Month Day Year 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician JOHN KENNETH McDONOUGH, JR.  $P^{M}$ 10,2208 5:45 MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8026 CARADOC DRIVE ROSEDALE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1**%** M 2 □ F 84 Yrs 216-14-0070 Director 10-17-1923 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at BALTIMORE ROSEDALE 1 ☐ Yes 2 XNo MD Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8026 CARADOC DRIVE 21237 U.S.A. Funeral 14. Race - American Indian . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 2 2 No If Yes , Give Year or Dates: 1 9 4 3 - 4 6 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify. Specify: WHITE ģ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry P.B. R. Elementary/Secondary (0-12) 1 2 than College (1-4or 5+) BRAKE MAN RAILROAD and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othany injury or other traumatic event Be JOHN KENNETH McDONOUGH, SR. MARGARET (MERRYMAN) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 909 HEDGEROW CT JOHN K. McDONOUGH, III/SON BEL AIR, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State 3-14-2008 BALTIMORE, OAKLAWN CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 21237 CHESACO AVE ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) diopothic **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran and Due to (or as a consequence of) the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by the Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tyes 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was ... autopsy performe Yes 21 certificate has steoarth 1∐ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient examiner/ 1 Yes 2 No Other: 4 Nursing Home P 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

death with the Maryland

filed within 72 hours after

altimore, Maryland 21215-0036

The law requires that the death certificate be executed Hospital or Attending death. after death filled in by within 24 hours a

20

State Registrar

Medical

29b. Signature and title of certifier

29a. Certifier

(Check only one)

and manner stated. 29c. License number

100291

DR-205

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

SQUARR

29d. Date signed (Month, Day, Year)

BATIMORE MD 21237

30. Name and address of person, no completed cause of death (Item 23a) (Type, Print)

NIENTO 9101 31. Date filed (Month, Day, Year) FRANILLIN 32. Registrar's Signature MAR 1 2 2008

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Physici /Medic		1. Decedent's Nam	ANN	MARCHS						2. Date of I Month MARC	Н		0 0 8 °C	3. Time of Death p 11:58 M	
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Funeral Director		5. Social Security N 217 38 Usual Residence of	8152	6. Sex 1 □ M 2 <b>X</b> F	7. Age (In yrs	s. last birthday Yrs.		Year Days	If Under 24 Hrs Hours Min		3irth 719	39	9. Birth	place (State or Foreign RYLAND	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed		Armed F	ive XNo	U.S. 13	. Was Deceder If Yes, specify 1 ☐ Yes 2		spanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or Note (1865)	10-		ack, White	ican Indian, , etc. VHITE	
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To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certificy completely filled in by the funeral director,	Certification:	2 Accident investigation M 1 Yes 2 No								t and Number or Rural Route Number, tate)					
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1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** MARC 1030DM AMUS 2008 /Medical County of Death lity Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UTUROCARE RNOLD RINDEI MOSAPOALLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Dec. 12, 1928 9. Birthplace Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1₩ 2□F Min. 79 PA 195-24-1333 Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28e-f show treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Arnold Director Anne Arundel MD 10g. Citizen of What Country? 10e Street and Number 10f, Zip Code USA 21012 695 Carlisle Drive Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Amed Forces? 1 Ayes 2 □ No If Yes, Give WWII Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Marned 2 Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2X No þ al Hygiene. other then "natural". 3 ☐ Widowed 4X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Cryptologist/Analyst permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other enyllory or other treumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sayde Victorine Unknown John Coulter Neil 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 695 Carlisle Dr., Arnold, MD 21012 19a. Informant's Name/Relationship (Type, Print) John B. Neil/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Marchie 15, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Silver Spring, MD Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707 M01053 23a. Pagh. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between set and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** ASPIRATION PNEUMONIA HOUR /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): Box 68760, attending physicien Completed by Physician/Medical igned by the attending p IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnat 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month 1 ☐ Yes 2 ☑ No Month Dav Year 4☐Pregnant at time of death Yes 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 ILAR DEMENTIA 3 Probably 4u Unknown 1 ☐ Yes 2 ☐ No page 2 should STAGE RENAL DISCASE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has certificate 2 No 1 ☐ Yes filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Leath Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: Sursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 -Natural 5 Pending Infury death. 1 □ Yes 2 □ No To the Hospitel or Attendi within 24 hours after death. To the Funerel Diractor: A investigation 2 Accident 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide tt Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number D46360 8601 Verennsttiernay MillorsvineHD 30. Name nd address of person who completed cause of death (ftem 23a) (Type, Print) ICHNEL 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008

DHMH 17 Rev 1/2001

Registrar

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland	-	artment of H		nd Mer	ntal Hygie Reg	6-0	0.8	08018
- 186 T	. 16	9	Decedent's Name (First, Middle, Last)					Date of Death			3. Time of Death
4. 24.	iysici: Medic	- 4	Edward William O'Brien					Month arch 3	Day 200	Year 8	4:00 A M
	camin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of	Death		4c. County	of Death	
ALE T	* . ?	25	4982 Sentinel Drive, Apt. 503		Bethesd				Monte	·	
	ieral		5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, Y	ear)	Coui	place (State or Foreign htry)
Dire	ctor		124-10-1014 91 Usual Residence of Decedent				0	ct. 29,	1916	New	York
yland	18			Town or Lo	ocation					1	Od. Inside City Limits
Mar a-f	E S	ctor	Maryland Montgomery Beth	esda							1 XYes 2 □ No
ith the	200	Directo	10e. Street and Number		10f. Zip Code			10g	. Citizen of \	What Cou	ntry?
ath w	TRAIL	ra	4982 Sentinel Drive, Apt. 503		20816				JSA		
er de	OBE O	Funeral	11. Marital Status  12. Was Decedent Ever in U.S Armed Forces?		Was Decedent of His If Yes, specify Cubar	spanic Origi n, Mexican,	in? (Specify Puerto Rica	Yes or No- an, etc.)		e - Americ ck, White,	ean Indian, etc.
)36 urs aft uf, or	728111	by F	1 ☐ Never Married 2 【X Married 1 ☐ Yes 2 X ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 🏌 No	Specify:			Specify	v: Wh	ite
1215-0036 within 72 hours after death with the Maryland ene. then "natural", or iteme 23a or 28a-f ehow	Cal E	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupa	tion		16	b. Kind of B	usiness/ln	dustry
212 thin 7	Med	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life.	kind of work done d DO NOT use retired)	uring most	or working				
2d with the state of the state	2	Sol	5+	Jour	nalist				ewspar		
be fill had	• Ven	Be	17. Father's Name (First, Middle, Last)					rst, Middle, Ma	iden Suman	ne)	
Maryland 21215-0036 d 2 should be filed within 72 hours at th and Mental Hygiene. 71 s marked other then "natural", or	natic	To	Dennis O'Brien  19a. Informant's Name/Relationship (Type, Print)	10h Mali	ng Address (Street a	Julia		anlan	iby or Tour	Ctata 7ia	Code
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23a or 28a-1 ehow	traur		Marian J. O'Brien - Wife								d., 20816
Heal	other		20a Method of Disposition 20b. Pla	ce of Dispo	sition (Name of		Date		c. Location -		
altimore, rmit. Pages 1 ar partment of Hea portent: If Item	ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lew 4 ☐ Donation 5 ☐ Other (Specify)	inerery, crei Insvi rch C	alory or other place IIe Presb emetery	ÿ•   <sub>3</sub>	/8/200	08 м	cLean.	Va.	22101
alti mit. F partm sorter	in in		21. Singline of Funeral Service Licensee		Name and Addres			-			laple Ave.
ä å ë	£ 8		M00968	Mo	ney & Kin	g Fun	eral	Home, I			Va. 22180
-	3		23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.					spiratory arrest	•		Approximate Interval Between
Physic	cian		Immediate Course (Final	dir	tery d	1500	150				Onset and Death  UEANS
/Med Exam			disease or condition resulting in death)  a. Or on any U  Due to (or as a consequence)	ence of):	1						7
LAdill			Sequentially list conditions b.								
/ Pg	Sit	ulue	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ence or):							
xecu	al-tra	Examiner	that initiated events resulting in death) Last C. Due to (or as a conseque	ence of):						-	
8760, sate be executed physicien and	the burial-transit	dical	d								
68 tificat ig phy	as th	led				_	_		-		
OX th cer endin	for use as	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal of		Ectopic pregnancy					te of delive	*
Records, P.O. Box 6: The law requires that the death certific tie has been signed by the attending p	of ber	Physician/Me	1 Yes 2 No		Other (specify)				Mo	onth	Day Year
P.O nat the d by th	be detached	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not result	in a in the	- 4-4-1	- in Book!		22a Did tahar		with the second	he cause of death?
dS, ires t signe	eq p	1 by	Atrial fibrillation	ang m me u	inderlying cause give	mmran.		1 ☐ Yes	2 000	3 ☐ Prot	
Vital Records, raicien: The law requires to certificete has been signer.	should	Completed									
Rec he lav	CI .	dw						24a. Was an autopsy performe		prior to co death?	ppsy findings available impletion of cause of
	rector, page	e Co	25. Was case referred to medical			OC Disease	of Dooth (C	1 ☐ Yes 2 ☐	KNo	1 🗌 Yes	2 (T) NO
ysicie	direct	To B	examiner? Hospital:	R/Outpatier	nt 3 DOA Othe	r.		5 Residence	e 6 DOth	er (Specii	(v)
VISION Of VITA  Attending Physicien: or death. ector: After this certifica	nerai		27. Manner of Death 28a. Date of Injury 2	8b. Time of		at		Describe how			,,
ision ( ttending F death. ctor: After	he fur	atlo	2 Accident investigation	mijury		es 2□N	0				
Division of lor Attending Phy after death. Director: After this	in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	ne, farm, str	eet, factory, office		28f.	Location (Stree City or Town, S		er or Rura	al Route Number,
pital ours al	pelli										
Divisit To the Hospital or Attenc within 24 hours after death To the Funerel Director:	completely filled	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	neage, death on and/or in	n occurred at the tim vestigation, in my op	e, date and inion, death	place, and occurred a	que to the caus it the time, date	e(s) and ma and place,	anner as s and due t	tated. o the cause(s)
o the	dwo	Me	29b. Signature and title of certifier	. A	29c. License	number		29d	Date signe	d (Month,	Day, Year)
->-	5		raturia Tomiko May,	MST	DC	051	916	1	Marc	h 3	3,2008
10			39 Name and address of person who completed cause of death (Item,	23а) (Туре,	Print)// I/	1	) , 4 -	n	(11	h	D same
10			Patricia Tomsko Nay, 1119 K	ocki	ille Pik	e, 6	-100,	Kock	V/1/18	2, 111	V 20852
	Sta	1.00	31. Date filed (Month, Day, Year) /32. Projektar's Signatu	re	1.	/				/	
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DHMH 17 Rev 1/2001

ORIGINAL

State Registrar

DHMH 17 Rev 1/2001

MAR 1 2 2686

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18 38 GREENE TREE 2010 #300 PILE



LEUNARD

PILESVILLE

RICHARDSON M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State of Maryland / Department of Health  1- State of Maryland / Department of Health  Certificate of Death			.2008	03020
F	Dhuaisia		1. Decedent's Name (First, Middle, Last)		Date of Death Month D	ay Year	3. Time of Death
•	Physicia /Medic		Gerard James Rolape		larch &		12:50 PM
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location		4	c. County of Deal	
7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			St. Mary's Hospital Leonardt			5+. M	
	Funeral Director		313-42-7165 1MM 2 F 65 Yrs. Months Days Hours	Min.	Date of Birth Month, Day, Yea Ine 12, 19		hplace (State or Foreign untry)
	w w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	f sho	5	Maryland St. Mary's Bushwood				1 ☐ Yes 2 No
	the 1	Director	10e. Street and Number 10f. Zip Code		10g C	Citizen of What Co	
	with sa or t be		21780 Beitzell Road 20618		109.0	US	, '
	ns 2%	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Or	rigin? (Specify	Yes or No-	14. Race - Ame	
(0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If teem 27 is marked other than "natural", or items 23a or 28a-f show important: If teem 27 is marked other than "natural", or items 25a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	큔	1 □ Never Married 2 Married 1 Mayes 2 □ No		ın, etc.)	Black, Whit	e, etc.
ဗ္ဗ	ours a	þ	3 □ Widowed 4 □ Divorced If Yes, Give Year or Dates: V. 2 + NAM	<i>/</i> :		Specify: W	hite
21215-0036	72 hc natul lical	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation	st of working	16b.	Kind of Business	Industry
7	ithin nan "	훁	Flementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)				
7	ould be filed with Mental Hygiene arked other tha atic event, the h		Manager				unications
Maryland	be fil ntal H ed otl	B			st, Middle, Maide		
7	2 should and Men is marke aumatic	ဥ				Bois	
Na Na	12 sh h and 7 is n traun	ш	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Numb				
	1 and 2 Health em 27 is		Mary Rolape / Wife 21780 Beitzell  20a. Method of Disposition (Name of	Rd E		Location - City or	
ק	Pages nent of H nt: If Ite		1 Rurial 2 Cromation 3 DRamoval from State   cemetery, crematory or other place)				
Baltimore,	permit. Pag Department Important: I any Injury o once.		4 Monation 5 Other (Specify) Anctorny 6 ifts Registry II 21. Signature of Fugeral Service Lightsee 22. Name and Address of Facility	March 71	5008 +	lanover	, 100
Ba	permit. Departr Importa any Inji		21. Signature of Funeral Service Librasee 22. Name and Address of Facility 7522 Connelley	, Drive	ony ait	ts Kegis	ND 21076
п	$\rightarrow$		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.			. 1100000	Approximate Interval Between
	Physician		Immediate Cause (Final			2,	Onset and Death
	/Medical		disease or condition resulting in death)  a				
В	Examiner						
		Je.	Sequentially list conditions, if any, leading to immediate  Cause First Indexiving  Due to (or as a consequence of):				
	ecutec nd ransi	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Dieses or nyur) that initiated events C.				
0,	e exe ian a urial-	<u>m</u>	resulting in death) Last Due to (or as a consequence of):				
68760,	tificate be executed g physician and as the burial-transit	edical	d				
9 x	ding page as		IF FEMALE: 23c. If yes, outcome pf pregnancy				
Вох	eath cer attendin for use	Physician/N	in the past 12 months?			23d. Date of de Month	livery Day Year
0	the d	ysic	1 Yes 2 No 9 Unknown 9 Unknown				
О.	that led by deta	됩	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	t I.	23e. Did tobacco	o use contribute to	the cause of death?
Vital Records,	Attending Physician: The law requires that the death cer cross that continued the continued of the attending the functal director, page 2 should be detached for use	d by	Chorno clisuse		1 ☐ Yes	2 □ No 3 □ P	robably 4. Onknown
Ö	w requir s been si should	ete	Gostuc Concer		24a. Was an	24b. Were a	utopsy findings available
æ	The la te has age 2	Completed			autopsy performed?	prior to death?	completion of cause of
ta	an: tifical tor, p		25. Was case referred to medical 26. Plac	ce of Death (Cf	1⊡ Yes 2 🛂 heck only one)	1 ☐ Yes	2 No
>	ysici is cer direct	o Be	examiner?   Hospital:			6 ☐Other (Spe	ecify)
0	ig Ph ter th	ü	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		Describe how in		
Ö	ath. ath. or: Af	atio	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐	□No			
Division or	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (Street Cify or Town, Sta	and Number or R ate)	ural Route Number,
	urs af			4			
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date a (Check only one)	and place, and eath occurred a	at the time, date a	and place, and du	s stated. e to the cause(s)
	To th Within To th	Me	29b. Signature and title of certifier 29c. License number			Date signed (Mon	
	. ()		29b. Signature and title of certifier  7 relacing MA  29c. License number  7 34/5			1/8/0	3
,	1/2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip J. Barrier M. J. J. J. Barrier M. J. J. Barrier M. J. J. J. Barrier M. J. J. Barrier M. J. J. J. Barrier M. J. J. J. Barrier M. J. J. J. Barrier M. J. J. J. J. Barrier M. J. J. J. Barrier M. J.	an med!	cal Center	/	21
	\		24039 Targee Notch R	Rd Holl	lywood, N	1D 206	<b>υ</b> φ
	Sta Registr		31. Date filed (Month, Day, Year)  32 Registrar's Signative				

Gerard James Kolape

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12,2008 Month **Physician** March Akhtar Raja /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Sinai Hospital of Balkinge 15a/timese If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pakistan 5. Social Security Number 7. Age (In vrs. last birthday) Funeral 1XM 2□F 103-72-5852 67 40 08 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland as Akhtar 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Hygiene. other than "natural" or items 23a or 28a-f show ent, the Medical Examiner must be notified at 1 TXYes 2 □ No Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21244 U.S.A. 1703 Fairbrook Ct. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Asian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Message Company Messenger 6th grade If Item 27 is marked other or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Serwar Begum Hussin Minhas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1703 Fairbrook Ct, Baltimore, 21244 Md <u>Shahbaz Raja-Son</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Dogation 5 Other (Specify) Kashmir 3/17/08 Khuiratta, Pakistan 21. Signature of Funeral Service Litensee March F/H West 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Inferction **Physician** M To lard 19 /Medical ue to (or as a consequence of): Examiner Incaracter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner T physician and s the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Actory Discase 1 ☐ Yes 2 ☐ No 3 ☐ Probably PYMIOTO Hiller Tension 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be 1 Yes 2 No Hospital: 1 in Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I completely filled ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basic of examination and/or investigation in the cause of examination and or investigation and o

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) MAR 12 2008 Registrar

29b. Signature and title of certifie

29a. Certifier (Check only one)

> 23 CrossRouds D #410

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

64316

Owings Mills

29d. Date signed (Month, Day, Year)

12

2004

March

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0815 AM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL JOHN KIND BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 💢 F Director 218-28-7491 8-2-1933 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No N/A Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 612 N. Ellwood Avenue S A 14. Race - American Indian, 21205 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes, 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🎇 No Specify. Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th grade N/A Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alfred Wilson Annie Smith ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jermaine Smith - Grandson 142 Spectator Lane Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐Removal from State King Memorial Park 3-14-08 4 □ Donation 5 □ Other (Specify) Randallstown, MD 22. Name and Address of Facility March F/H 21. Signature of Funeral Service Licensee East 21202 1101 E. North Avenue Balto, Hones 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HOURS LARDIOGENI /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed PERTENS attending physician and for use as the burial-tran-Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 5 Other (specify) signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, DISORDER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 0401 has page 2 autopsy performed' certificate 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier N53368 MARCH 11 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , THE JOHNS HOPKINS HOSPITAL, 600 N. WOIFEST, BALTIMORE, MD 21287

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryla		artme rtifica			nd Me	_	gienė Reg. No.	008	080	23
	Physici /Medi		1. Decedent's Name (First, Middle, Las Beatrice T. Rav	ulinas						Date of De Month	ath Day 29	2 Year	3. Time of 1341	Death M
	Examir Funeral Director		4a. Facility Name (If not institution, give NorThur ST HOSP, TQ 5. Social Security Number 6. S 214-40-4858	1	s. last birthday) Yrs.	Ran	alls Te	If Under 24	Hrs. 8.	. Date of Birl (Month, Da	1	C		r Foreign
	nyland how		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Lo								10d. Inside Cit	
	th the Ma or 28a-f s	Irecto	MD  10e. Street and Number		Baltime		p Code				10g. Citi	zen of What C	1 Yes	2 🗌 No
920	be filed within 72 hours after death with the Maryland nat Hygiene. od other then "neturel", or items 23a or 28a-f show event, i'm Medical Examinar must be portified at	by Funeral Director	3544 Lynchester  11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	Road  12. Was Decedent Ever in Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		Was Dece If Yes, spo	dent of Hi orify Cuba	215 spanic Origin n, Mexican, F Specify:	n? (Specif Puerto Ric	fy Yes or No can, etc.)	]	USA  14. Race - Am Black, Wh  Specify: b	ite, etc.	
Maryland 21215-0036	within 72 ho lene. 'then "netur	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed)  College (1-4or 5+) 5+		dent's Usi kind of w DO NOT	ork done a	luring most of	f working	unk		nd of Business	,	
yland 2	should be filed nd Mental Hygi marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) William E. Tat					18. Mother's		First, Middle,				
	1 end 2 shi Health and tem 27 is m		19a. Informant's Name/Relationship (7 Earlean Hairsto	• •		_		<i>nd Number o</i> l Avenu				Town, State,		
Baltimore,	Pages ment of ent: If it		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specify	Removal from State	Place of Dispo cemetery, crea	osition (Na matory or	me of other place	<b>9</b> )	Date	θ	20c. Lo	cation - City o	r Town, State	
Balt	permit. Departi import any in		21. Signature of Euneral Service Licen	Wade, Directo		ate altim			ard 6 1201	555 W.	Bal	timore	Street	
	Physician /Medical Examiner	Examiner	23a. Part1\Enter the disease, or composition shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	one cause on each line.	FORTICE of ):	2.17	de of dying	), such as ca	rdiac or ri	espiratory ar	rrest,		Approximate Interval Beth Onset and I	ween
8760,	icate be executed physicien and s the burial-transit	cal	that initiated events resulting in death) Last	c. Due to (or as a conse	equence of):									
P.O. Box 6	death certif e attending od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal déath 3	∃Ectopic p ∃Other <i>(s</i>					2	23d. Date of de Month		/ear
	quires thet n signed b uld be deta	Ď	Part II. Other significant conditions co	ontributing to death but not re	esulting in the u	nderlying	cause give	n in Part I.			obacco u Yes 2		to the cause of d	
al Records,	Physicien: The law requires thet the this certificate has been signed by the rail director, page 2 should be detached.	Completed												
Division of Vital	To the Hospital or Attending Physicien: The law within 24 bours ether death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation: To Be	25. Was case referred to medical examiner?  1 D Yes 2 No  27. Manner of Death  1 D Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)			28c. Injury Work	4 🗀 (Aut 2)	ng Home		dence (	S □Other (Sp.	ecify)	
Divis	ai or Atte s efter des bi Directo ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factor	y, office		28f	Location (S City or Tov	Street and vn, State	d Number or F )	Rural Route Num	ber,
	the Hospital hin 24 hours of the Funerel I upletely filled	edical	29a. Certifier 1 € Certifying Ph (Check only one) 2 ☐ Medical Exam	rsician: To the best of my kiner: On the basis of examinand manner stated.	nuwledge deat nation and/or in	h securisc vestigation	at the tim	a, data and p inion, death (	occurred	due to the at the time,	rause(s) date and	and illamor to place, and du	e to the cause(s	)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	7		1	c. License						oth, Day, Year)	,
		1	30. Name and address of person who o	completed cause of death (Ite	em 23a) (Type,	Print)	000	1316 1115 /		17	<i><b>P</b>5104</i>	r 29	2008	
	Sta	te	Sicre T Shindel MD  31. Date filed (Month, Day, Year)	23 Cross Doc/5 38. Registrar's Sign	#4/0	OW!	nys M	1.115 /	nD	21117	7			
	Registr		MAR 1 2 200	Jo per sure d	S. ASSE									

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	, FUI	partment of Health and Nertificate of Death	Tental Hygiei	2000	08024
(C)	Physici	an	1. Decedent's Name (First, Middle, Last)  DHN  LITCHICK		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  Levindale Health Center	4b. City, Town, or Location of Death Baltimore	L	4c. County of Death	00013
12	uneral rector		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda $191-09-0229$ 7. Age (In yrs. last birthda $92$ 7. Age (In yrs. last birthda $92$ 7. Age (In yrs. last birthda $92$ 8. Age (In yrs. last birthda $9$		8. Date of Birth (Month, Day, Ye Apr 6, 19	ar)   Coun	lace (State or Foreign try)
faryland	show ed at	or	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Howard	Location Ellicott City		1	0d. Inside City Limits
vith the N	or 28a-f	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Coun	
d 21215-0036 flied within 72 hours after death with the Maryland Hygiene.	If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral	2525 Melba Road  11. Marital Status  1 Never Married 2 Married Forces?  1 Yes, Give	3. Was Decedent of Hispanic Origin? (Sprif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	USA 14. Race - Americ Black, White,	
Baltimore, Maryland 21215-0036 remit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene.	"natural", c dical Exan	eted by	15. Decedent's Education (Specify only highest grade completed)  16a. Dec	1 ☐ Yes 2 ☐ No Specify:  Dedent's Usual Occupation  we kind of work done during most of work.	ing 16b	Specify: Whi	
2121 led within lygiene.	her than ' it, the Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired)  Onstruction Worker		Construction	on
aryland should be fi	arked oti	To Be	17. Father's Name (First, Middle, Last) Albert Ritchick	Mildr	e (First, Middle, Maid ced Dlucei	.n	
and 2 sh	n 27 is m ier traum		Mrs. Donna Sinquefield (Daughter) 25	iling Address (Street and Number or Rura 25 Melba Rd., Ellic	,		Code)
imore Pages 1 ment of H	ant: If iter ury or oth		1 N Burial 2 Cremation 3 N Removal from State	position ( <i>Name of</i> rematory or other place) te Heart of Mary 3/		Linwood, F	
Baltimo permit. Pag Department	Important: It any injury o once.		1 Dun C. Hangy Moo169 1:	22 Name and Address of Facility HAIGHT FUNERAL HOME Sykesville, MD 2178	34		195)
Phys	sician		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	enter the mode of dying, such as cardiac of			Approximate Interval Between Onset and Death
144	edical miner		Due to (or as a consequence of):				
ecuted	and T	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
38760, cate be executed	physician and F s the bural-transit	dical	Due to (or as a consequence of):				
Sertifi Sertifi	attending for use as	Physician/Me		B⊟Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
dS, P.	igne be d	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part i.		co use contribute to th	_
Vital Records, P.O. Booklean: The law requires that the death	e has been si age 2 should t	Completed	- VALVULAR HEART DISTASE		24a. Was an autopsy performed	prior to cor death?	psy findings available npletion of cause of
VITal sician:	ector	Be	25. Was case referred to medical examiner?  Hospital: Hospital:		1 Yes 2		2 □ No
n Or		ation: To	27. Manner of Death   Natural   5   Pending   2   Accident   2   ER/Outpation   2   ER/Ou	of 28c. Injury at	me 5 ☐ Residence 28d. Describe how in		/)
DIVISIO	af Director: ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	t and Number or Rura tate)	l Route Number,
DIVIS To the Hospital or Att within 24 hours after de	ne Funera	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal control of the best of my knowledge, deal call examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
Tot	SO E	ž	29b. Signature and title of certifier  Physician	29c. License number	29d.	Date signed (Month, 1	Day, Year)
	5		30. Name and address of person who completed cause of death (Item 23a) (Type BARAMNSE AJANI MD 21		Are BAU	CENTER.	2/2/5
F	Sta Registra		31. Date filed (Month, Day, Year)  MAR 1 2 2008  32. Figistrar's Signature				

Registrar

State

31. Date filed (Month, Day,

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2008 t ner 10 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A CTR care Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan 25, 1907 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Days Months 1 □ M 2 👿 F Maryland 220-07-0113 101 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Baltimore 1 Yes 2 No N/A Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21230 1300 South Charles St., USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🚺 No Specify Specify: ģ White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Montgomery Ward Co. Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John W. Ruppert, Sr. Helen Schmidt 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 80883 Spendthrift Lane, Port St. Lucie, F1. 34986 (Son-in-law) Robert T. Sommers Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/17/08 Baltimore, Maryland Cedar Hill Cemetery 4 Donation 5 Dother (Specify) 2 Name Address of Facility Runeral Home, P.A. Raltimore, Md. 21230 21. Signature of Juneral Solvice Licensee Kevin E Ecker 130 E. Fort Ave., Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NementlA **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it are a list in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2.☑1√No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 🗆 DOA 1 ☐ Yes 2 ☐ No 2 ER/Outpatient Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Deatural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) State Registrar

MMM

Don

Ummi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



5102

March 12, 2008

Baltimore marylano

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARCH 08:17FM Joseph Howard Richmond, Sr.

4a. Facility Name (If not institution, give street and number)

4b. City 27, 2008 /Medical 4c. County of Death b. City, Town, or Location of Death Examiner Joseph Medical Center Saint Baltimore Towson If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Funeral Days 1 MM 2□F Months Hours Min. Director MD Usual Residence of Decedent Nov 3, 1917 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ns 23a or 28a-f shov must be notified at 1 ☐ Yes 2 No Director **Timonium** MD **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a death Funeral 2525 Pot Spring Rd. 21093 Was Decedent Ever in U.S. Armed Forces? 1 Des 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or iten 1 Never Married 2 Married 2XN0 3altimore, Maryland 21215-0036 1 Tyes Specify Completed by If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Governent Systems Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Margaret Garvis Bruno Allen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph H. Richmond, Jr. Son Metgod of Disposition 3152 Emerald Valley RD. Ellicott City, MD 21042

20b. Place of Disposition (Name of cametery, crematory or other place)

20c. Location 20a 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 Rurial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Clarksville, Maryland St. Louis Cometery Mar 11, 2008 of Funeral Service Licensee Slack Funeral Home, P.A.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) signed by the at d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ACUTE RENAL FAILURE 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 1 ☐ Yes 3 Probably 4 Unknown After this certificate has been s funeral director, page 2 should METLASTATIC PROSTATE CANCER 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**K** No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury (Month, Day Year) 1 Natural To the Hospital or Attendli within 24 hours after death. To the Funeral Director: Al M 1 □ Yes 2 □ No 2 ☐ Accident filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7-08 D30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVER TOWSON, MARYLAND 21204 FRANCIS KHOO. M. D 31. Date filed (Month, Day, Year) MAR 1 2 32. Regirar's Signature State 2008 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day 1. Decedent's Name (First, Middle, Last) **Physician** Kenneth 1206 AM March 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A BACTIMDEE (
If Under 1 Year | If Under 24 Hrs. | SOHNS HOPKIN OSPITAL Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X** M/ 2 □ F 186-26-8461 69 1938 PA Director July 6. Usual Residence of Decedent 10c. Cify, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Ex-miner must be notified at York 1 ☐ Yes 2 XNo York PA Director 10g. Citizen of What Country? 10e. Street and Number USA 17402 1020 Hastings Blvd Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ¬Yes 2 ¬No 7,1955 If Yes, Give Year or Dates: 7,1959 72 hours after 1 □ Never Married 2 □ Married White 1 ☐ Yes 2 ☒ No 3altimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7: h and Mental Hygiene. 7 Is marked other than "n Office Furniture Elementary/Secondary (0-12) College (1-4or 5+) Installer 8th grade 18. Mother's Name (First Middle, Maiden Surname)
Mary Miller 17. Father's Name (First, Middle, Last) Kenneth Stambaugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 Is
any Injury or other trau P.O. Box 3913 York, PA 17402 Mark Stambaugh /Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Susquehanna Memoria 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) York, PA 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Lice 5240 Reisterstown Rd Baltimore, Md 21215 Harris 3a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus Final disease or condition resulting in death) Multisystem week **Physician** orgen /Medical Due to (or as a consequence of): Examiner PSIS Sequentially list conditions, france leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to fir as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed cance 26 Sonhas burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the IF FEMALE nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? 1☐ Yes 2 No death? 1 ☐ Yes 2 🗆 No Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation after death.

I Director: Aid in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated

within 24 hours at To the Funeral C completely filled i

State Registrar

DHMH 17 Rev 1/2001

C

31. Date filed (Month, Day, 2008

Kemp

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 15:32 M Edward Swinson 03 01 2008 Gene 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) SINAL HOSCITAL OF BALTIMIRE N/A Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 🗙 🛠 77 217-24-1970 17, 1930 Virginia Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Yes 2 No N/A Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21215 4630 Pimlico Road 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes XXNo Specify. 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife unk. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 21201 Odessa Reed James Cost 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21201 626 W. Franklin Street APt. Raltimore Md 19a. Informant's Name/Relationship (Type. Print) Patricia Cost/ Daughter Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Cam10/08 tv Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, Maryland Crownsville V.A. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Funeral Service Licensee 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MULTIS YSTEM CREAM FAILURE 11 days Due to (or as a consequence of): ARDIOGENIC 13 days SHOOK Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Colonary askly alseas Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? DIABETES 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No - all moles gut 24a. Was an autopsy perform 1□ Yes 2☑No 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

item 27 other t

Department of Important: If it any injury or o

Pages 1

requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

**Physician** 

/Medical

Examiner

Directo

Funeral

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

death with the Maryland

Maryland 21215-0036

Baltimore,

ストット

Examiner burial-transi Physician/Medical ate has been signed page 2 should be det Completed by funeral director. Be Medical Certification: To

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

28a. Date of Injury (Month, Day Year)

28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

 $\square . 0$ 

29d. Date signed (Month, Day, Year) 5008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. HAMED 31. Date filed (Month, Day, Year)

Interior nellahe Resident

State Registrar

this

After Attending

death.

hours after deat

within 24 hours at To the Funeral C

filled in by

	Phy /N Exa	/sic led ami
Division of Vital Records, P.O. Box 68760,	al or Attending Physician: The law requires that the death certificate be executed	arier deam.  I Director: After this certificate has been signed by the attending physicien and

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	•	For Stata Registrar		State of IVI	arytario		tificate o				Reg. No.	UUC	) Uč	1030
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Physicia /Medic			S. School							MARC	H 0	2, 20 County of	1800	:45PM
Examin	er		If not institution, give	_			4b. City, Towr			ANNE		30 M	FPC:	ET
F		5. Social Security N		ANOR 7. AS	e (In yrs. la	st birthday)	If Under 1 Ye	ar if Und	555 er 24 Hrs.	8. Date of Bir	th	9	). Birthplace (	State or Foreign
Funeral Director		214-24-0	- 11	□ M 25 F	79	Yrs.	Months Day	/s Hours	s Min.	(Month, Da Aug 26	$\frac{19}{19}$	28	Country) New Je	rsey
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shov	5	10a. State	Worceste	ar.	Toc. City,	Poco								Tyes 2√TNo
28a-1	Director	10e. Street and Nu		- L		1000	10f. Zip Cod				10g. Citi	zen of Wh	at Country?	
ath with the Marylan 1238 or 288-f show	10	201 6th							.857			USA		
ltema 2:	Funeral	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S	i. 13. V	Was Decedent	of Hispanic (	Origin? (Sp	ecify Yes or No Rican, etc.)	)-		American Inc	dian,
urs af	by	1 Never Marr	ried 2⊠ Married 4 □Divorced	1 Tes, Give	No		1 ☐ Yes 2🌠			Thous, oto.,			white	
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should nd Mer marke	욘		lame/Relationship ()			19b. Mailin	ng Address (Str	eet and Nun		ra/ Route Numb		r Town, St	tate, Zip Code	a)
nd 2 suith ar 27 is r trau		William	n Schoolfi	le1d/spous	e	206	óth Str	eet Po	ocomol	ke, MD	2185	57		
permit. Pages 1 and 2 should be Department of Health and Mental Important; If Item 27 Is marked to any injury or other traumatic evenance.			position  Cremation 3   5 Other (Specify		20b. Pla ce	ace of Dispo metery, cren	sition (Name or natory or other	olace)	i i	Date	20c. Lo	ocation - C	ity or Town, S	tate
permit. Departm Importa any inju		21. Signature of E	uneral Serve Licen	Wade, Dir	ector		Name and Ad State Ar altimor			d 655 W	І. Ва	1timo	ore Sti	reet
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w require been si should l	etec	4/13/1	C /- 171	c. CCA	<i></i>					24a. Wa	s an	24h W	ere autoosy fi	indings available
The larate has	Completed by Physician/N						· · · · · · · · · · · · · · · · · · ·			auto		pri de	ior to complet eath? Yes 2	ion of cause of
Physician: Th this certificate ral director, pag	Be	25. Was case refe examiner?		Hospital:				Othor		th (Check only				
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ding th. : After	tion	1 ☐ Natural 2 ☐ Accident	5 Pending investigation	28a. Date of Inj (Month, D	ay Year)	Injury		Work? 1 ∐ Yes 2	! □ No					
Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific Mely filled in by the funeral director,	Certification:	3 Suicide 4 Homicide	6 Could not b	e 28e. Place of Ir	jury - At ho tc. (Specify		reet, factory, off	ice		28f. Location City or To			r or Rural Rou	ute Number,
To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exar	ysician: To the bes niner: On the basis and manner s	of examinat	wledge, deat ion and/or in	h occurred at the	e time, date ny opinion,	and place death occu	, and due to the rred at the time	e cause(s , date an	i) and man d place, ar	ner as stated nd due to the	cause(s)
within 2 To the comple	Me	29b. Signature and	d title of certifier	~				ense numb				_	(Month, Day,	
			Der.	' X	n	70	_   2	006	2916	6	MA	RCH	3, 2	008
		30. Name and add	dress of person who	FRREZ	/	415	Print)							y Mg 2/80
Sta	ate	31. Date filed (Mo.	onth, Day, Year)	32 Regis	rar's Signa	иге	and I							•

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0803 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician SCHWARTZ** HANNAH 9 11:15 80 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KESWICK NURSING HOME BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/08/1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours Min. 1 □ M 2 🔏 F 109-14-7493 89 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 CROSS KEYS ROAD 21210 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ Specify: 3 Widowed 4 Divorced "naturai" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) other than ADMINISTRATOR UNIVERSITY OF MARYLAND 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **SCHWARTZ** HYMAN MINNIE VALVO is marked ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a SUSAN SNYDER / NIECE 100 HARBORVIEW DRIVE, BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of I Important; If Itt any injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State CARROLL CREMATION 03/11/2008 HAMPSTEAD, MD 5 ☐ Other (Specify) 4 □ Donation 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. durned Immediate Cause (Final **Physician** Alzhein eus disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner alluve Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use copyfibute to the cause of death? by 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an has autopsy this certificate 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Vinertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

within 24 hours at To the Funeral D Hospitai

Registrar

VIJA 31. Date filed (Month, Day, Year) MAR 1 2 2008

29b. Signature and title of certifier

(Check only one)

1600 W. MT. Registrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

D0064788

29d. Date signed (Month, Day, Year)

2008

State

OR Sheldon

31. Date filed (Month, Day, Year)

MAR 1 2 2008

ESSA

FRANKLIN Square DR Balto

21237

9000

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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		For State Registrar			•	tificate of		Mental Hy	Reg. No.	08	08033
Physicia /Medic		1. Decedent's Name (First, Middle La Rue B. Schn	,					2. Date of D March	10 <sup>D</sup> 2008	Year	3. Time of Death 1:25 A M
Examin		4a. Facility Name (If not institution		nber)			or Location of De	ath		y of Death	
		Gilchrist Cent  5. Social Security Number		7. Age (In yrs.	last hirthday)	Towsor		rs. 8. Date of B	irth	timore	ace (State or Foreign
uneral irector		214 22 7982 Usual Residence of Decedent	1 □ M 2 □ F	80	Yrs.	Months Days			1927	Count	nore, Maryland
Important: If the Tris marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ŗ	10a. State 10b. County			y, Town or Loc					10	Od. Inside City Limits  1  Yes 2 No
28a-f notifie	Director	Maryland Baltim  10e. Street and Number	ore	Ba.	ltimore (	10f. Zip Code			10g. Citizen of	What Count	try?
t be r	Ö	9831 Fox Hill Road				21128			USA		
Snm.	Funeral	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13. V	Vas Decedent of	Hispanic Origin?	(Specify Yes or Nerto Rican, etc.)		ce - America	
xaminer	by	1 ☐ Never Married 2 ☐ Marri 3 ☐ X Widowed 4 ☐ Divorced	If Yes, Giv	2 <b>X</b> No e		TYes, specily Co		erto nicari, etc.)	Speci	ick, White, e fy: Whit	
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dic e	To E	Lloyd Loundes Bea	tty				Ethel O	nambers			
arma		19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailin	g Address (Stree	et and Number or	Rural Route Num	ber, City or Towr	n, State, Zip	Code)
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y or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (\$		State	cemetery, cren	sition (Name of natory or other p atorsy Tro	ace) March 1	Date 1 2008	20c. Location  Baltimor	•	
Importar any injur once.		21. Signature of Funeral Service	Licensee	TE		2. Name and Add ASSANN FUI	ress of Facility Peral Hone	Inc			ICH KI
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tely filled in by the funeral director, page 2 should be detached for use	Certification: To Be Completed by	25. Was case referred to medical examiner?  1   Yes   20   No  27. Manner of Death 1   Natural   5   Pendial investing a suicide   6   Could   4   Homicide   Check only   2   Medical   Medical   2	Hospital: 1 1 28a. Date (Monigation not be nined 28e. Place building Physician: To the Lexaminer: On the b	npatient 2 of injury h, Day Year) of injury - At h ng, etc. (Speci	ER/Outpatien  28b. Time of Injury  ome, farm, str	nt 3 DOA C f 28c. In W M 1 eet, factory, office	26. Place of lither: 4 □ Nursin jury at ork? □ Yes 2 □ No e time, date and p	24a. Wa pu	yes 22No as an 24b topsy (one) sidence 6 e how injury occu (Street and Num own, State)	3 ☐ Prob  . Were auto prior to cor death? 1 ☐ Yes  ther (Specifiurred	psy findings available mpletion of cause of 2 No  No  HOSPICE  If Route Number,
To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the line.	To Be Completed by	25. Was case referred to medica examiner?  1 Yes 27 No  27. Manner of Death 18 Natural 5 Pendii investi 2 Accident investi 3 Suicide 6 Could detern  29a. Certifier 18 Certifyi	Hospital: 1 1 28a. Date (Monigation not be hined 28e. Place building Physician: To the Examiner: On the band man	npatient 2 □ of Injury th, Day Year) of injury - At h ng, etc. (Speci	ER/Outpatien  28b. Time of Injury  ome, farm, str	nt 3 DOA C f 28c. In M 1 reet, factory, offic h occurred at the vestigation, in m	26. Place of lither: 4 □ Nursin jury at ork? □ Yes 2 □ No e time, date and p	24a. Wa au p   1   2   2   2   2   2   2   2   2   2	yes 22No as an 24b topsy (one) sidence 6 e how injury occu (Street and Num own, State)	3 ☐ Prob  . Were auto prior to cord death? 1 ☐ Yes  ther (Specify purred  manner as see, and due to	psy findings available mpletion of cause of 2 No  No  HOSPICE  If Route Number,  tated. To the cause(s)

State Registrar

DHMH 17 Rev 1/2001

0 6505 NCHARLES ST. SUITE 209
32. Februar's Signature

BALTIMORE, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN, MD

31. Date filed (Month, Day, Year)

MAR 12 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Richard Smith Р Ruben March 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Laurel Regional Hospital Laurel Prince George's If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 □ F 59 North Carolina May 9, 1948 Director 041-36-9025 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director MD Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 67 S. Paula Street 20724 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify. Specify: White þ 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12th Ø <u>Painter</u> Self-Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertie Smith Thelnita Helen Robinson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Desaray Helen Smith/Daughter Maryland Avenue NE, #203, Washington, DC 20002 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/11/2008 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. Odenton, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Euneral Service Licensee **№**101103 313 Talbott Avenue, Laurel, 23a. Part1. Enter le disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or le ht failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau (Final disease or condition resulting in death) **Physician** Pneumonia Week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause Unisease or nijery that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2\text{XNo} 24a. Was an autopsy performed? Yes 2∏No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2X ER/Outpatient 3 DOA 1 Inpatient P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

P.O. Box 68760, Division or Vital Records,

requires that the death certificate be executed burial-transi and physician the attending for use the a signed by t page 2 certificate | this funeral After t

death with the Maryland

filed within 72 hours after

permit. Pages 1 and 2 should be filed be propartment of Health and Mental Hygic Important: If item 27 is marked other 1 any Injury or other traumatic event, the

Baltimore, Maryland 21215-0036

r 28a-f show notifled at

r than "natural", or items 23a or the Medical Examiner must be r

ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After the filled in by within 2

State

Medical

29a. Certifier (Check only one) 29b. Signature and title of certifier

3 Suicide

4 Homicide

6 Could not be determined

and manner stated.

29c. License number

D23685

1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

3/8/2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter R. Hammond, MD 10937 31. Date filed (Month, Day, Year)

2008

32. Régistrar's Signature

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Broad Green Terrace, Potomac, MD

MD

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2005 Robert Louis Steele 0 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore ROSE dale Frankin Square Hospita If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday 1**X** M 2□ F Months Days Hours Min. 214-26-5708 75 09-20-1932 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No Maryland Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 13202 Cherwin Avenue 21220 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 M Yes 2 No If Yes, Give Year or Dates; 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Caption/Officer Baltimore City 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert L. Steele Edna Marie Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Steele (Wife) 13202 Cherwin Ave. Baltimore, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 03-11-2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee Busin a. Will 9705 Belair Rd Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ard109 Due to (or as a consmuence of): Hypertension. 250 Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No y one) esidence 6 Other (Specify) e how injury occurred

Physician /Medical Examiner

Important: If any injury o

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Director

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Certification:

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ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, <u>the Medical Examiner must be notified at</u>

Pages 1 and 2 should be f nent of Health and Mental I ant: If item 27 is marked of

3altimore, Maryland 21215-0036

Robert

and the burial physician as 1 for use signed by the a has

Box 68760,

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Division or Vital Records,

Physician/Medical certificate After this

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(Check only one)

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25. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
27. Manner of Death  ↑ Natural 5 ☐ Pending 2 ☐ Accident investigati	on M	Injury at 28d. Describe how injury occurred Work? 1 □ Yes 2 □ No								
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		fice 28f. Location (Street and Number or Rural Route Number, City or Town, State)								

building, etc. (Specify) 29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

9000 Franklin Square Drive Ball + more, MD 21257 Maria 31. Date filed (Month, Day, Year)

State Registrar

To the Hospital or Attending Prwithin 24 hours after death.

To the Funeral Director; After it completely filled in by the funeral

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | | | | | | 1 - Stete Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 11, Physician 2008 6:15A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street an 4b. City, Town, or Location of Death Examiner Baltimore Oak Crest Care Center Parkville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 8. Date of Birth | Months | 06-24 + 1916 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Maryland 1 □ M 2 X F 91 212-07-8376 Yrs. Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location Oa. State r then "natural", or items 23a or 28e-f show the Medical Examinar must be notified at Baltimore Parkville Maryland 1 Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 8800 Walther Blvd. 21234 filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: ģ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Salesperson 8 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other traumatic event one. 17. Father's Name (First, Middle, Last) Mary Donohue Patrick Flaherty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) Germantown, MD 20874 12417M Hickory Tree Way Mary Anne Stafford - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland New Catherdral Cem. 03/14/2008 4 ☐ Donation 5 ☐ Other (Specify) 5305 Harford Road of Funeral Service Liceusee 22. Name and Address of Facility Leonard J. Ruck, 21. Signatur Inc. Baltimore, Maryland 21214 Mun Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Meumona /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Que to for as a consequence of attending physician and I for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death signed by the at d be detached fo 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1□ Yes 2 - HC To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifical 26. Place of Death (Check only one) 25. Was case referred to medical Other: A Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Beath 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred Certification: 1-Natural 5 Pending М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29s Cortifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marker as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c Name and address of perspn who completed cause of death (Item 23a) (Type, Print) 8800 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

08-01814

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more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. In the Maryland Mental Hygiene and the Maryland, or items 23a or 28a-f sht on the I. If item 27 is marked other than "natural", or items 23a or 28a-f sht or other traumatic event, the Medical Examiner must be notified at once a contract of the Commission of the Firmeral Director		0a. Method of Disposition  201. Place of Disposition (Name of cemetery, prematory or other place)  Shifting Francisco (Same of Disposition (Name of cemetery, prematory or other place)  Shifting Francisco (Same of Disposition (Name of cemetery, prematory or other place)	001	V. Va.	Variation of
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours al Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examinative or other traumatic event, the Medical Examinative or other traumatic event, the Medical Examinative or other traumatic event, the Medical Examination or the performance of the Commission of the performance of the performance of the commission of the performance of the perfor	1.	4 Donation 5 Other Specify:	14/2003	Ba Nan	Socraices
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Within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, trate (	29d. Date signed	Month, Day, Year)
) F \$ F 5	ž	29b. Signature and title of certifier  29c. License number  O.C.M.E.		March 4, 2008	
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		30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltim	ore, MD 2120	1	
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ss 1 and 20 Health Itam 27 other tra		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of matory or other place		Date		tion - City or		
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교원관	Si .	21. Signature of Funeral Service L	icensee	/		. Name and Addres					timore Av	zenue
Deen Transfer of the contract	a	Claudett	a Dasch	Janni	-	asch's Fu				attsvi		2078 L
		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cause only one cause on each	ed the death. D	ne lee o	er the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Betwee Onset and Deal	
Physicial	_	Immediate Cause (Final disease or condition	a as	pera	Ju	- me	umor	ua_			1 ch	3
/Medica Examine	•	resulting in death)	Due to (or a	consequence	ce of):	ar	rent				INC	
		Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequence	ce of):		1	2	*			-
uted uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>S</b> .	(	In	onay 1	wites	du	lan	t	900	n
be executed sician and burial-transit		resulting in death) Last	Due to (or a	s a consequenc	ce of):	1	1				9	
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ath ce	lan/	23b. Was decedent pregnant in the past 12 months?		e or pregnancy 2 ∏ Fetal dea at time of death		Ectopic pregnancy Other (specify)			230	d. Date of del Month	Day Yea	r
he de	ysic	1 Yes No	9 Unknown	at time of death	1 30	Otter (specify)						
w requires that the deben signed by the should be detached		Part II. Other significant condition	ns contributing to death	but not resultin	g in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use	contribute to	the cause of deat	.h?
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The It	E			-		J		perfo	rmed? 2 No	death?	2 □ No	
ician: Sertifica ector, p	BeC	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only o				
hysic hysic nis ce	To	1 Yes 2 No	Hospital: 1 Inpai		Outpatie		4 Nulsing Fi	ome 5 Resid			ecify)	
ing Phy Mer this		27. Manner of Death  1 Natural 5 Pending		jury 28 Day Year)	b. Time o Injury	Wor		28d. Describe	now injury (	occurred		
tending death. tor: Afte	cati	2 Accident investig	not be	nium. At homo	form of		Yes 2 No	28f Location (5	Street and	Number or R	ural Route Number	r.
or All after of Direction by	Certification:	4 Homicide determ		etc. (Specify)	i, iaiiii, si	reet, factory, office		City or Tov				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours attended and the Trothe Funeral Director. Attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 12 Certifyin	ng Physician: To the bes	st of my knowle	dge, dea	th occurred at the tir	ne, date and place	, and due to the	cause(s) a	nd manner a	s stated.	
ne Ho 1 24 h ne Fur (etely	edical	(Check only 2 Medical one)	Examiner: On the basis and manner	of examination	and/or in	nvestigation, in my o	pinion, death occu	rred at the time,	date and p	and du	e to the cause(s)	
To th within To th comp	Me	29b. Signature and title of certifier	1112	1,1	7/ 1.7	29c. Licens	e number		29d. Date	signed (Mon	th, Day, Year)	c
		TYTH Ch	100	KW/6	1 000	1 0	6143	δ	1010	un	01,000	0
10		30. Name and address of person	who completed cause of	death (Item 23	Ba) (Type	Print) - DE	YAKET	TIGH W	An An	WAPOL	07,200 SMD214	FU,
Salah Salah Mila	State	31. Date filed (Month, Day, Year)	32 Aeai:	strar's Signature	9		10:030 1	1917	1		,	-
	State Ístrar	MAD 19	2008	10		reles						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Joelettlie Tatum MARCH 1700 /Medical 2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital Baltimore Sinai 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept 7, 19 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🗑 F Director 238-24-5591 85 North Carolina Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits other than "natural", or items 23a or 28a-f showent, the Medical Examiner must be notified at 1 √ Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 4139 Forest Park Avenue 21207 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No black Completed by Specify: 3 ☐ Widowed 4 💆 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) maid Md General Hospital 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be Kathlyn Mullins ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Brown/caregiver Health a 4139 Forest Park Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) State Anatomy Board 655 W. B

23a. Part! Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line.

Immediate cause (Final disease or condition resulting in death)

a. Sephic shoot. 21. Signature of Funeral Service Licensee Ronald'S. Wade, State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 **Physician** 3 DAYS /Medical Due to (or as a consequence of): Examiner DHEUMMIA Sequentially list conditions, if any, leading to immediate outset. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Demember 54-5 attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical Hyperkenslas. IF FEMALE: for use . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 2 2 No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours af To the Funeral D 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

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716 Maiden choice lone

32. Registrar's Signature

A September

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OESAIM

MAR 1 2 2008

31. Date filed (Month, Day, Year)

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314/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per fh 8877 3-11-08 vt. State of Maryland Phepartment of Health and Mental Hygiene Reg. No.2 0 0 8 08040 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 09 2008 9:00 AMM 03 Edward Stonewall Tochterman, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 8800 Walther Blvd. - Apt. 4306 Baltimore, Maryland 8. Date of Birth (Month, Day, Year) 10/18/1915 Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 1XM 2□F 92 Director 216-01-5172 Maryland Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notifled at 1 ☐ Yes 2 No Director Baltimore Baltimore MD 10g. Citizen of What Country? 10e Street and Number 10f Zin Code 21234 U.S.A. 8800 Walther Blvd. - Apt. 4306 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify <u>ک</u> Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Tochterman's Tackle Shop Store Owner 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anne Fires Fries ပ Thomas George Tochterman, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sl Department of Health and Important: If Item 27 is n any Injury or other traum 21087 11411 Cedar Lane - Kingsville, Maryland Edward S. Tochterman, Jr. (son) Ob. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State 03/14/2008 | Baltimore, Maryland Oak Lawn Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee When #88ahr 11750 Belair Road - Kingsville, Maryland 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stro Physician Minutes /Medical Due to (or as a consequence of): Vascular Difease Examiner terosclesofi if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) Hospital or Attending Pl 24 hours after death.
 Euneral Director: After the 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 Tyes 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours a Medical 29a, Certifier \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title Attending MD 10, 2008 Name and address of person who completed cause of death (Item 23a) (Type, Print) 351 M.D. SCHWART 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar MAR 1 2 2008

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Louise A. Taylor March 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Belair Health and Rehabilitation Center 00 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9-18-21 9. Birthplace (State or Foreign Country)
Md. 7. Age (In vrs. last birthday) Social Security Number 6. Sex **Funeral** 1□M 2□F Months 220-05-3950 Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a, State 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Harford Md. Jarrettsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examiner must be n one. 21084 3205 Melde Ct. USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

X
1 □ Yes 2 □ No Specify: 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ 136 If Yes, Give 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 3€Widowed 4 □ Divorced White Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Trust Analyst Bank 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Stoewer Rose Limpert ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Stuart 3205 Melde Ct. 21084 Jarrettsville, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-10-08 Gardens Of Faith Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. 21236 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each light Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law lequires that the death certificate be executed Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has b en 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an autopsy performe Division or Vital 1□ Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 일 1 Yes 2 XNo 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier 1 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29c. License number 29d, Date signed (Month, Day, Year) FACO f person who completed cause of death (Item 23a) (Type) Print) 31. Date filed (Month, Day, istrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ALAN TURNIANSKY March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hospital Baltmore of Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex 1 X M 2 ☐ F Date of Birth (Month, Day, **Funeral** Months 143-48-4248 Director 06/14/1956 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County show at r 28a-f sh notified BALTIMORE MD BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 4112 LOWELL DRIVE 21208 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced item 27 Is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COMPUTER PROGRAMMER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be TURNIANSKY SIMON **JEANETTE** ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL TURNIANSKY / BROTHER 4112 LOWELL DRIVE, BALTIMORE, MD 20b. Place of Disposition (Name of BE Ameter), Acemptory or other place)
ADATH ISRAEL CONG 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ò permit. Page Department of Important: If any injury or once. 03/11/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Subarac hnoid hemorinage /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical physi the I SB attending properties for use as IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 24a. Was an page performed or Attending Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital 1 Yes 2 No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital

atten, MBBS

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

duy 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 21110 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🚅 certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) RES-000 10,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BHARAT RATTAN, MBBS Sinai Hospilal of Baltimore

5:00 PM

Birthplace (State or Foreign Country)

WHITE

MD 21208

Approximate Interval Between Onset and Death

NY

10d. Inside City Limits

1 ☐ Yes 2 X No

12008

N/A

USA

14. Race - American Indian,

COMPUTERS

KRANTZ

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR 1 2 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 8:00 SUSANNA March 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Schenley Baltimore if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min. 1□ M 2**X**F Months Days 218-45-4153 England January 29, 194 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. County 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1XYes 2 No NIA Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4620 Schenley Road 21210 Completed by Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐Yes 2 No FYes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 "natural", or Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than Marketing Assistant Insurance 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be Goby James Wilhemina Martin Wykes ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimorer Road Schenley MD 21210 Sergeant Charles 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 March 7, 2008 Hasover, Anatomy Gifts Registry Injury 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee Drive Suite P. Hanover, MD 21076 1522 Connelley 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER. 10 yrs **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, aftending physician Physician/Medical as the IF FEMALE: ase 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death ned by the aften e detached for u Month Year in the past 12 months? 5 ☐ Other (specify) 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 21XNo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 027730 3/10/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES 21264 CONEN 6569 32 Projetrar signatu State Registrar

State of Maryland / Department of Health and Mental Hygiene 0804 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 10, 2008 **Physician** Pamela Sue Wagner 4:51 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 53 Tollgate Road Owings Mills Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 18, 1949 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 F 58 WasHIngton 219-54-7980 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Owings Mills Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 53 Tollgate Rd. U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNC Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Temp. Agency Temporary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donald Wagner Betty Nelson ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 824 E. "B" Street, Brunswick, MD. 21716 Robert Wagner - brother 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory March 12,2008 Baltimore, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Falls al-Septice Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 mun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lineumonia week disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner mysem sem eavs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Lest Due to (or a a consequence of) Examiner The law requires that the death certificate be executed burial-transit attending physician and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 4□Pregnant at time of death 9□Unknown in the past 12 months? Month Day Year 5 ☐ Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacço use contribute to the cause of death? Completed by sorder 1 Pres 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has N autopsy page perform hotes After this certificate d or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 100 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 1 Matural completely filled in by the funeral 28a Date of Injury 28h Time of 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a 1 McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2 2008

82. Registrar's Signature

# AVARILL P WILDBERGERBaltimore, Maryland 21215-0036

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To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	Physician: To the best camîner: On the basis of and manner st	of examina	wledge, deat ation and/or in	th occurred at the ti	ime, dat opinion,	te and place, death occur	and due to the red at the time	cause , date a	(s) and m and place	anner as , and due	stated. to the cause(s)
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Physician /Medical Examiner **Funeral** WADE, MARGARE 218-26-8045 Director Usual Residence of Decedent 10a State r 28a-f show notified at Director Marvland 10e. Street and Number 7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be r 11 Marital Status 3altimore, Maryland 21215-0036 þ Completed d 2 should be filed w th and Mental Hygier 7 is marked other th Be Raleigh ၉ item 27 other tra 20a. Method of Disposition Pages 1 Department of Important: If it any Injury or o mediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760, physician Physician/Medical the use as IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 2 No ed by the a detached f signed b þ funeral director, page 2 should Completed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 WADE MARGARET 9 0820 AM MARCH 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL BALTIMORE WASHINGTON MEDICAL CENTER GLEN BURNIE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 🛣 F 76 Sept. Virginia 02,1931 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Crofton Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 21114 U.S.A. 1571 Chapman Road 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Housewife Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Atkins Bessie Mae Foster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1571 Chapman Road, Crofton, Maryland 21114 (Daughter) Diana L. Sigler 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery | 03-13-08 Brooklyn Park, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. XIM 130 East Fort Avenue, Baltimore, Maryland 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Emphysema Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed?

1 Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2No 1 npatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mm 2008 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington Medical Franci MD 31. Date filed (Month, Day, Year) MAR 12 2008

DHMH 17 Rev 1/2001

State

Registrar

Hospital or Attending Physician:

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To the Funeral Director: A

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Certification: To

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*	Physicia	_	1. Decedent's Name (First, Middle, Last)  Arthur E. Wheeler				2. Date of Death March	88 2008	3. Time of Death 8:07 рм
	/Medic Examin	Street,	4a. Facility Name (If not institution, give street and number) Blakehurst		4b. City, Town, or Towson	Location of Death		4c. County of Death Baltimore	
12	Funeral Director		5. Social Security Number 6. Sex 1 → 7. Age (In yrs 207–14–6050 1 → 81	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day Aug. 28,	Year 926 Pen	place (State or Foreign nry) nrsylvania
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036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in L Armed Forces?  1 Yes, Give Year or Dates:	1	Was Decedent of His f Yes, specify Cubar 1 □ Yes 🎾 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
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P.O. Box	The law requires that the death certifute has been signed by the attending bage 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf preging the pregnant at time of golden and the pregnant at time at the pregnant at time at time at the pregnant at time	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	very Day Year
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Division or Vital Records,		Completed	Cerebrovascular diseas	e			24a. Was ar autops perforn 1□ Yes 2	y prior to c	opsy findings available ompletion of cause of 2 ☐ No
Vita	ysictan: The I is certificate ha director, page	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 [	☐ ER/Outpatier	nt 3□ DOA Othe	1	th <i>(Ch</i> eck only one ome 5 ☐ Reside	ence 6 🗆 Other (Spec	ify)
o uc	ling Phys After this funeral dir		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	/ at		ow injury occurred	
Divisio	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, I	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At building, etc. (Special Could not be determined 29e. (Special Could not be determined 29e.)	home, farm, str cify)		163 2 110	28f. Location (St. City or Town	reet and Number or Ru n, State)	ral Route Number,
	e Hospita 24 hours e Funeral letely fille	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my king the physician of examiner: On the basis of examiner and manner stated.						
	To th within To th	Me	29b. Signature and title of certifier	, ,,	29c. License	number Q Z/	77_ /	9d. Date signed (Month	, Day, Year)
)	ハメ		30. Name and address of person who completed cause of death (life	em 23a) (Type,	Print) N	70 30	7 1	WINI IU	120
1	7	10	AAAON. J. CHMUS W. 31. Date filed (Month, Day, Year) 32. Marar's Sig	6 [0]	N. Cha	was st	- 10NSO,	N NO Z	1204
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			1 - For State Registrar	State of Ma	ai yiai iu	-			Death	WEIIIAI		g. No.	008	0804	8
ı	Physici	an	1. Decedent's Name (First, Middle, Las							2. Date Mont MAR		_	Year Year	3. Time of Death	
	/Medic	al	STEPHANIE  4a. Facility Name (If not institution, give		LSON		Ah Cihi	Town or	Location of Deatl		. 8	, 20 C	ounty of Deat	10:25 A	MVI
	Examin	er	GILCHRIST H	,			4D. City	TOWS		18		BALTIMORE			
-	Funeral		5. Social Security Number 6. S	ex 7. Age	e (In yrs. las	st birthday)		r 1 Year	If Under 24 Hrs.	8. Date	of Birth	1	9. Birt	nplace (State or Foreiguntry)	ign
ш	Director			□M 2□F	46	Yrs.	Months	Days	Hours Min.	DEC	h, Day, 13	,196	51 MI		
	and www.		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location								10d. Inside City Limit	its		
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	h the or 28a e noti	Director	MD   N/A   BALTIMORE   10e. Street and Number   10f. Zip Code   10g. Citizen or 2229 HOMEWOOD AVE.   21218   USA								n of What Co	untry?			
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	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		13.	Was Dece If Yes, spe	dent of Hi ecify Cuba	spanic Origin? (S in, Mexican, Puert	pecify Yes to Rican, etc	or No-	14	. Race - Ame Black, White		
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and	ed d o	o Be	STEPHEN WILS						ROSA G			aldon be	arramo,		
Maryland 21215-0036	2 should by and Menta is marked aumatic ev	ဥ	19a. Informant's Name/Relationship (			19b. Mailir	ng Addres	s (Street a	and Number or Ru	ıral Route I	lumber,	City or T	own, State, Z	lip Code)	
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		ROSA WILSON(da	ughter)					DD AVE.						
Baltimore,	e = 5		20a. Method of Disposition 1 ☐ Burial 2 ※ X remation 3 ☐	Removal from State	cen	ce of Dispo netery, crei	natory or	other plac		18°,2	- 1		tion - City or		
<u>=</u>	t. Pa ntmen rtant:		4 Donation 5 ☐ Other (Specify 21 Stanature of Funeral Service Licen	) [	GRE				EMATORY			BALT	ro, MD.	•	
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 26 Month 2 **Physician** KEZA ESFAHANI LAREH 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Adventist Rockville Montgomer HOSP Grove 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4 30 19 **Funeral** 1 M 2□F 79 928 IRAN Director Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland ersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2087 IRAN by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Yaman 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Governmen 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Metid ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) KHATAMI (NIECE) 85 Genither's burg MDZO877 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 Bunal 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee t. Woodbridge Easy 2 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician curcula /Medical Due to (or as a consequence of): Examiner evere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the burial-transit attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 The law requires that the death certificate be Physician/Medical as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? Month Day Year signed by the at d be detached for 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Nown 1 ☐ Yes been si should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s this certificate has autopsy performed? 10 2 No or Attending Physician; director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2**2** No 1**X**Inpatient 2 2 ER/Outpatient 3□ DOA completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3□ Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the Hospital or Attend within 24 hours after death To the Funeral Director:

State Registrar

Meenakshi 31. Date filed (Month, Day, Year)

30. Name and address of person who completed

29b. Signature and title of certifie

12 2008 MAR

Registrar's Signature

cause of death (item 23a) (Type, Print)

edical Center Dr. Rockvill MD. 20850

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 1 - For Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ZINK Month Physician IRVIN 2008 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Nursing Center Baltimore City Baltimore If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) April 20 1919 **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 □ F Baltimore, Maryland Yrs. Director 21.3 03 1416 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 23 e marked other then "natural", or iteme 23e or 28e-f show any follury or other traumatic event, the Medical Examiner must be multiled at 10a, State 10b. County or then "natural, or Iteme 23s or 28s-f show the Medical Exeminer must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Baltimore Maryland Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4715 Ridgeway Avenue 21206 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry uring most of working Elementary/Secondary (0-12) College (1-4or 5+) NASign Mechanic Sign Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Zink Anna Wiseman ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) I. Joseph Zink, Jr. (Son) 4707 Breidenbaugh Lane Glen Arm, Maryland 21.057 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. March 11 2008 Baltimore, Maryland 21 Signature of Funeral Service Ligensee Import any Inj pace. 22. Name and Address of Facility Lassann Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** bro vascu /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as Examine consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 ☐ Unknown s been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by nknown 1 Yes 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? res 20 No 1 Yes 200 No 1□ Yes or Attending Physicien: To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number. City or Town, State) 4 | Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year)

1 1 2005 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 2Ba) (Type Print) woll 31. Date filed (Month 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2-26-08 Day Physician 11:59 AM ANDERSON VIVIAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY ROCKVILLE 10500 ROCKVILLE PIKE #901 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) **Funeral** PHILA", PA 1 ☐ M 2 ☐ XF Director 196-20-3025 9-5-1930 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or itams 23e or 28e-f show the Medical Examiner must be notified at 1X Yes 2 □ No Director MONTGOMERY ROCKVILLE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20817 U.S.A. #901 10500 ROCKVILLE PIKE by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ MNo If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) STATE DEPT. ADMINISTRATIVE ASSISTANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event 2008. Be SIMMONS CARRIE TURNER COUNTLEY ပ 19a. Informant's Name/Relationship (Type, Print)
KENNETH COUNTLEY— NEPHEW 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19 HILLERY CIRCLE NEW CASTLE, DELAWARE 19720 20c. Location - City or Town, StatePHILA. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1201 EASTON RD. PA 1915 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-14-08 IVY HILL CEM. & CREM. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PINCKNEY-SPANGLER F. H. 524 - 8TH ST., N. E. WASH., DC 20002-5236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. to not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) stroke **Physician** /Medical Due to (or as a consequence of): trial fibrillation
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2 drabetes wellitus Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 1 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 1 Residence 6 ☐ Other (Specify) Certification: To 1 TYes 2 □ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident al or Attend after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapped stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0064059 FEB. 27, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10215 FERNWOOD ROAD DAVE CHEN, M. D. #100 BETHESDA, MD 20817 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 2 9 ZUUD Registrar

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Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

24a. Was an 2 No 1□ Yes

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 Tyes 6 ☐ Could not be

3□ DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient

Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifie

d cause of death (Item 30, Name and address of pe 7500 HAN OVER PKWY #101A GREENBELT MO 2070

(MD) 29c, License number 066658

29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year) 2008 9

**SRINEH** 

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

27. Maryher of Death

1 12 Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760.

The law requires that the death certificate be executed

			1 - State of Mar Registrar	-	artment of He rtificate of D		, ,	ene g. No. 2008	3 0805
	Physicia	'n	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Betty Jane Bloyer				Februar	y 29 2008	1207 AM
)	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L			4c. County of Dea	
To May	Funeral			(In yrs. last birthday)	Hagerstow If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9 Bir	thplace (State or Foreign ountry)
i	Director		212-24-3563 1 M 2X F Usual Residence of Decedent	80 Yrs.			Nov. 19,	1927   Ma	ryľand
	yland now at			Oc. City, Town or Lo	cation				10d. Inside City Limits
	e Mar 8a-f sl	ctor	Maryland Washington	Williams					1 □Yes 2 🔀 No
	with the	Dir	10.7.1.2 Hopourfield Bood		10f. Zip Code			g. Citizen of What Co	ountry?
	death ms 23	Funeral Director	10712 Honeyfield Road  11. Marital Status 12. Was Decedent Evo	er in U.S. 13. 1	21795 Was Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Spe		ISA 14. Race - Ame	
-0030	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1  Never Married 2 Married I  See See See See See See See See See		_ 4	Specify:	Rican, etc.)	Black, Whit	
ņ	72 ho 'natur dical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupati kind of work done du DO NOT use retired)	tion uring most of worki	ing 1	6b. Kind of Business	/Industry
7	within ene. than he Me	dmo	Elementary/Secondary (0-12) College (1-4or 5+)		oo not use retired) emaker	-		Home	
and 2	e filed al Hygi other vent, t	BeC	17. Father's Name (First, Middle, Last)	TIOME		18. Mother's Name			
ylar	ould b Menta arked	20	John Eli Cline	т т		Minnie		Hut	
Mar	d 2 sh th and th and 7 Is m traum		19a. Informant's Name/Relationship (Type. Print)  Debra Hoover (Daughter)	1	ng Address <i>(Street an</i> 4 M <b>†.</b> Ae <b>†n</b>				
บ์	s 1 an f Heal Item 2 other		20a. Method of Disposition		sition (Name of natory or other place)			Oc. Location - City or	
	Page nent o ant: If ury or		1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Spegify)				4,2008 W	'illiamspo	rt, Maryland
Dallillor	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra once.		21. Signature of Funeral Service Licensee	05 S-	Name and Address Sporne Fun Treet Will	of Facility ieral Hom iamsport	e P.A. 4	25 South (	Conococheagu
6	100		23a. Part1. Enter the dilease, or complications that caused the shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death
,	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Fail	we				Onset and Death
	Examiner		Due to (or as a c	onsequence of):					
å	p #	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underfying Cause (Disease or Injury that initiated events	consequence of):					
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	consequence of):					
0/00,	ificate be executed g physician and as the burial-transit	edical E	d.	onsequence or,					
0			IF FEMALE:						
O. DO.	The law requires that the death cert ate has been signed by the attending page 2 should be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 S 2 No 9 Unknown 2 23c. If yes, outcome pf 1 Live birth 2 4 Pregnant at tir	☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	that the part of t		Part II. Other significant conditions contributing to death but r	not resulting in the ur	nderlying cause given	in Part I.	23e. Did toba	acco use contribute to	the cause of death?
, DIC	equire; en sig ould be	ed b	E-Coli LVINZUY TYGOT	INTO	cTan		1 ☐ Yes	s 2□No 3□P	robably 4 □Unknown
מנ	has be	Completed by	phemia of chronic	nisee	se	<i>h</i>	24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
g	an: TI tificate tor, pa	မ္မ	25. What ase referred to pedical	Mellon	2, IN) 110	26. Place of Death	ivac 1□ Yes 2	☑No 1 ☐ Yes	2 □ No
-	hysich his cer I direc	10 B	examiner? 1 Yes 2 100 Hospital: 1 Impatient	2 ER/Outpatien	Othor			rce 6 □Other (Spe	cify)
5	ding P		27. Manne eath 1 C atural 5 Pending (Month, Day Y	/ear) 28b. Time of Injury	Work?	at es 2 □ No	28d. Describe hov	v injury occurred	
200	Attendent r death ector:	Certification:		- At home, farm, stre			28f. Location (Stre	eet and Number or Ri	ural Route Number,
5	tal or rs afte ral Dir led in	Cert	4 Homicide determined building, etc. (	эреспу)			City or Town,	State)	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one)  1	xamination and/or inv					
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. License n	number	29	d. Date signed (Mont	-
			June Q Deese	20	H00	61117	F	ehrvary	29,2008
2	14-2		30. Name and address of person who completed cause of deat  New CCS CS A D a M	h (Item 23a) (Type	Print) 25	1 EUV	Inteta	0 3/74	07 _
F	Sta	е	31. Date filed (Month, Day, Year) 32. Registrar's	Signature	ric	17/1/10	700	1/0(1)	
	Registra	ır	MAR 0 4 2008	. do	1				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of		Mental Hy	giene 0	08 08055
, x	Physici /Medio		Decedent's Name (First, Middle, Last)     IRENE			BOGART	Y	2. Date of De Month MARCH	Day	3. Time of Death 2008 2:45 P M
	Examir		4a. Facility Name (If not institution, give s				or Location of Death		4c. County	
3		Щ	FOREST HILL HEALT				REST HILL			IARFORD
* * * * * * * * * * * * * * * * * * *	Funeral Director		CT4-CC-4300	M 2 <b>M</b> F 7. Age	e (In yrs. last birthday 82 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 12/12	ay, Year)	9. Birthplace (State or Foreign Country) Maryland
	land t		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	Mary -f sho fied a	ţ	MD. Harfo	rd			Jarrett	swille	2	1 ☐ Yes 2 No
	h the	Director	10e. Street and Number			10f. Zip Code	00,1100	01222	10g. Citizen of V	Vhat Country?
	th wit 23a c 1st be		2044 Cox Ro	ad			21084		Unite	d States
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	I2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	Ever in U.S. 13	. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No		pecify Yes or No Rican, etc.)	14. Race Blace Specify	e - American Indian, k, White, etc. White
Maryland 21215-0036	72 hour "natural	Completed t	15. Decedent's Educ (Specify only highest grade	cation	16a. Dec	edent's Usual Occup e kind of work done DO NOT use retire	oation during most of work	king	16b. Kind of Bu	rsiness/Industry
12	withir ene. than he Me	dmc	Elementary/Secondary (0-12)	College (1-4or 5	+)	Housew				Home
<u>0</u>	should be filed valued be marked other imatic event, the	Be Co	17. Father's Name (First, Middle, Last)			Housew	T	ne (First, Middle	, Maiden Surnam	
<u>a</u>	should be and Mental s marked o	To B	Benjamin		Burto	n	An	na	M	enninger
ary	2 short and N is ma	_	19a. Informant's Name/Relationship (Тур	oe. Print)	19b. Mai	ling Address (Street	and Number or Ru	ral Route Numb		
	1 and 2 Health em 27		Jean A. Bogarty	(Daugh		3 Cox R	oad J			, Md. 21084
ore	Pages 1 nent of H int: If ite iry or otl		20a. Method of Disposition  1	emoval from State	20b. Place of Disp cemetery, cr	osition (Name of ematory or other pla	1 4	Date	20c. Location -	City or Town, State
timore,	t. Pa rtmen rtant: rjury		4 ☐ Donation 5 ☐ Other (Specify)			Mary Ce		1/08	Pylesv	ille, MD.
Ba	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License			22. Name and Addre		arrett	sville	, Maryland
ŧ	14500		23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that cause	the death. Do not e					Home, P.A.
	Physician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	DE	MAN.	ITA				Interval Between Onset and Death
	Examiner			Due to (or as a	a consequence of):					(
		Jer	Sequentially list conditions, if any, leading to immediate		a consequence of):					
	ecuted nd transii	Examiner	that initiated events							
90,	fficate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a	a consequence of):					
68760	cate b physic the b	edical	d	-						
_	= D #	/Me	IF FEMALE:	3c. If yes, outcome p	of pregnancy				and Dat	
Box .	The law requires that the death cert te has been signed by the attending age 2 should be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1□Live birth 4□Pregnant at	2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	у		Moi	e of delivery nth Day Year
J.	ires that the de signed by the a be detached t	hys	9 Unknown	9□Unknown						
	res th igned be de	þ	Part II. Other significant conditions con	tributing to death bu	t not resulting in the	underlying cause giv	en in Part I.			ibute to the cause of death?
0	w requir been si should b	eted						ا ا	Yes 2 No	3 Probably 4 ☐ Winknown
Vital Records,	ne faw has b je 2 s	Completed					<u> </u>	24a. Was auto	psy	Nere autopsy findings available of to completion of cause of
g			25. Was case referred to medical					1□ Yes	2 ☑ No 1	leath? ☐Yes 2☐ No
5	rsicla s certi lirecto	o Be	examiner?	ospital:	nt 2 ☐ ER/Outpatie	ent 3 DOA Oth	er:			(0 - " )
ō	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Injur	y 28b. Time				dence 6 Other	
Ö	ath. or: Aft	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury		K? Yes 2 □ No			
DIVISION	l or Atte after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inju building, etc	ry - At home, farm, s . (Specify)	treet, factory, office		28f. Location ( City or To	Street and Number wn, State)	er or Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certification completely filled in by the funeral director.	edical C	29a. Certifier (Check only one)	er: On the basis of	examination and/or i	th occurred at the til	me, date and place, opinion, death occu	and due to the	cause(s) and ma , date and place, a	nner as stated. and due to the cause(s)
	o the vithin ; o the comple	Med	29b. Signature and title of certifier	and manner stat	led.	29c. Licens	e number	Т	29d. Date signed	I (Month, Day, Year)
<b>)</b>	⊢≯⊢ō		1 March 1	SH	_	028	3131		3-7-5	2
7			30. Name and address of person who cor	npleted cause of de	ath (Item 23a) (Type	, Print)	0130			<u> </u>
_					CPHAIL RO		L AIR, MI	2101	14	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature					

Registrar

DHMH 17 Rev 1/2001

MAR 1 3 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 7:40 PM Jean BERGMAN FEB 26 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROCKVILLE HEBREW HOME OF GREATER NASHINGTON MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 4, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 M 2 X New Jersey 91 242-46-1904 Director Usual Residence of Decedent 10c. City, Town or Location show 10b. County 10d. Inside City Limits r 28a-f sh notified Directo 1 ☐ Yes 2 ☐ No Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? p o rai", or Items 23a Examiner must b 10566 Metropolitan Avenue 20895 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural", or ther other traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give X Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: white 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerical U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Meyer Werber Mary Wolfson ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marc Wagshal, Nephew 6130 Lux Lane, Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 Donation 5 Dother (Specify) King David Memorial Garden 02/28/08 Falls Church, VA 21. Signature of Funeral Service Licen 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 23a. Part1. Emer the disease, or complications that caused the death. Do not men he was a sound or each shock, or heart failure. List only one cause on each line. 20012 Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PNEUMONIA PAYS /Medical Due to (or as a consequence of): Examiner PAYS Sequentially list conditions, if any lasting to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine CAD YEARS as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2⊠No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð RENAL FAILURE, ANEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed OSTEOPOROSIS HTN DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D57284 FEB 27 2008 true Kohan, MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKVILLE MD 20852

State Registrar

ANNA KORZAN,

FEB 2 8 2008

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Begmow

6105

32 Registrar's Signature

MP

MONTROSE RD

State of Maryland / Department of Health and Mer	ntal Hygien
Certificate of Death	Reg. No

			For State Registrar	Oldio of file	,		ificate of I		···oniai ·	Reg. N	.200	8 08057
П	Physici	an	Decedent's Name (First, Middle	, Last)					2. Date of Month	D	Day Yea	
	/Medic	al	Dolores Barker  4a. Facility Name (If not institution	give atmost and number)			4b. City, Town, or	Location of Dea		/22/2	.008 lc. County of D	1:00pm <sup>M</sup>
	Examin	ier -	Spa Creek	give street and number)		-	Annar				nne Aru	
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birt	1	If Under 1 Year Months Days			Birth Day, Yea	9. 1	Birthplace (State or Foreign Country)
Ц	Director		577-28-4481 Usual Residence of Decedent	ILIM ZMF	88	Yrs.				/1919		NY
	land ow at		10a. State 10b. County		10c. City, Town	or Loca	tion					10d. Inside City Limits
	a-f sh	tor	MD Anne	Arundel	Ode	ento	n					1 □Yes 2X No
	a with the	Funeral Director	10e. Street and Number 492 St. Barbar	a Lane			10f. Zip Code	1113		10g. C	Citizen of What	Country?
	death	nera	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Wa	as Decedent of H Yes, specify Cuba	ispanic Origin? (	Specify Yes or	No-		merican Indian,
980	be filed within 72 hours after death with the Maryland that Hyglene. So other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed ※ ※ Divorced		No		∐Yes 2x⊡XNo	Specify:			Specify:Wh	
5-0	72 h	Completed by	15. Decedent (Specify only highes	's Education t grade completed)	16a.	Deceder	nt's Usual Occup nd of work done o D NOT use retired	ation during most of wo	orking	16b.	Kind of Busine	ss/Industry
121	within ene. than '	ldmo	Elementary/Secondary (0-12)	College (1-4or 5	j+)		eptionis				Federa	1 Government
<b>d</b> 2	filed Hygid Sther ent, th		17. Father's Name (First, Middle,	Last)	1	ILC C	Сретопта	18. Mother's Na	me (First, Mid	idle, Maide		ir government
lan,	Aental Aental rked o	To Be	Joseph Bladen					Nelli	e Linga	ıu		
Maryland 21215-0036	is and 2 should be filed within Health and Mental Hygiene. tem 27 Is marked other than tenter traumatic event, the Me	-		a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City of 492 St. Barbara Lane Odenton, M								
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 Is marke any injury or other traumatic once.			cemetery, crematory or other place)							Location - City altimor	or Town, State
alti	permit. Departm Importa any inju		21. Signature of Funeral Service Licenses   22. Name and Address of Facility Hardesty Funeral								eral Ho	me, P.A.
8	8 2 E 8 9		Dalas of	arc			2 Ridgel	-		<del></del>	MD 214	
ı			23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that caused only one cause on each li	ne.		,					Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	a consequence of		cherical	Ine	mm	a		2 wh
	Examiner			<b>1</b> b		,-						
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):						
	recute and I-trans	Examiner	that initiated events resulting in death) Last	c	a consequence	of):						
68760,	icate be executed physician and s the burial-transit					,						
	tificate ig phy. as the	Medical		u								
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ № 9 ☐ Unknowh	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a' 9 □ Unknown	2 Fetal death		Ectopic pregnancy Other <i>(specify)</i>	y		_	23d. Date of Month	delivery Day Year
	s that ned by	by Ph	Part II. Other significant condition	ons contributing to death b	ut not resulting ir	n the und	lerlying cause giv	en in Part I.	23e. [	Did tobacc	o use contribut	e to the cause of death?
ğ	w require been sig should b									Yes	2 <b>/≥</b> No 3□	Probably 4 Unknown
Records,	The law re te has be age 2 sho	Completed								Vas an autopsy performed es 2	prior deat	e autopsy findings available to completion of cause of h?
Vital	sician: The certificate har rector, page	Be C	25. Was case referred to medical examiner?					26. Place of De				
or V	<u>S</u> .≌ <del>S</del>	Tol	1 ☐ Yes 2 → No	Hospital:				4/C_TNursing			6 □Other (5	Specify)
	ing After	ion:	27. Manner of Death  27. Natural 5 ☐ Pendin investig	28a. Date of Inju (Month, Da	y Year) 28b.	Time of njury	28c. injur Wor M 1 □	ryat rk? Yes 2∐No	28d. Desci	ibe how in	njury occurred	
Division	or Attending after death. Director: After in by the fune	Certification:	2 ☐ Accident IIIVestig 3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	not be 28e. Place of inj	ury - At home, fa c. (Specify)	ırm, stree		100 20110		on (Street Town, St		r Rural Route Number,
I	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	edical Ce		g Physician: To the best Examiner: On the basis o and manner st	of examination an							
	To the within To the Somple	Mec	29b. Signature and title of certifie				29c. Licens	se number		29d. [	Date signed (M	Ionth, Day, Year)
		1	1 × 1/4 / 1/4	cours			13.	7926		2,	12511	800
		7	30. Name and address of person	more of	leath (Item 23a) (	(Type, Pi	ach Writ	re Ch	. L. M	0 0	21619	
	Sta Regist		31. Date filed (Month, Day, Year)	2008 32 legistr	rar's Signature	4	well .					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Feb.  $24^{\text{Day}}$ 2008 8:28 PM Dale Chase-Williams /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Clinton Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 05-22-1958 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 2 😡 F 49 Maryland Director 216-74-4647 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 23a or 28a-f shov almportant: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Fairmont Heights MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 USA 1010 58th Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No **Black** Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foster Care Mother Private Industry 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ball Charles Bell ပ 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10406 Thrift Road 19a. Informant's Name/Relationship (Type. Print) Mary Wilkerson (Mother) Clinton, 35 Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Harmony Mem. Park 03-03-08 4 ☐ Donation 5 ☐ Other (Specify) Landover, MD Name and Address of Facility alph Williams Funeral 813 Potomac Ave.,SE; W 21. Signature of Juperal Service Licensee 22. Nam Ral 181 Service Wash., 20003 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) VASKules Mislase **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months 1 Yes 2 No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a 9□Unknown 9 🗀 Unknown signed by the Part II. Other significant conditions contributing to geath, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 1 Yes Completed peen 24b Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an certificate has b rector, page 2 s autopsy 2 □ No 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 10 3 DOA 1 Inpatient 2 ER/Outpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident filled in by the 6 ☐Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 2 who completed cause of death (Item 23a) (Type, Print) 30 Name and address 31. Date filed (Month) State FEB 2 9 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician**  $\mathbf{a}^{-M}$ Teresa Ciffolilli February 26, 2008 9:55 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Potomac Valley Nursing & Wellness Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Months Days 1 ☐ M 2 🛣 F Director 577-34-1071 79 June 28, 1928 Washington, Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show Items 23a or 28a-f shoviner must be notified at 1 ☐ Yes 2 No Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10112 Tenbrook Drive 20901 USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner Black, White, etc. is 1 and 2 should be filed within 72 hours after of Health and Mental Hyglene. Item 27 is marked other than "natural", or item other traumatic event, the Medical Examinies. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Specify:White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Paralegal Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Ciffolilli Maria Benedetti ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amelia J. Stellabotte/Sister 10112 Tenbrook Drive, Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 20c. Location - City or Town, State 20a. Method of Disposition 29, permit. Pages 1 Department of I-Important: If Ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2008 Silver Spring, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service License 500 University Blvd, W., Silver Spring, MD 2090 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or comp shock, or heart failure. List only company to the company of the company ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tuse on each line. Immediate Cause (Final **Physician** 60 days disease or condition resulting in death) /Medical Examiner Advanced Dementia Sequentially list conditions, if any, leading to immediate cause. Lists Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed burial-transi Exami and Due to (or as a consequence of) Box 68760 attending physician for use as the buris Physician/Medical IF FFMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy Day Year 5 Other (specify) ed by the a detached f P.O. 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Chronic Kidney Disease Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed Division or Vital 1∐ Yes 2 XNo Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident the within 24 hours after death
To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 0 the Hospital 🛱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) D62435 February 27, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Center Drive, Rockville, MD 20850 Sayed Elsayyad, MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB

2 8 2003

32 Registrar's Signature

			For State Registrar	State of Marylan		rtment of F			giene Reg. No 20	30	08060
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath		3. Time of Death
\$7	Physicia		George	Cobb.Jr.				February	19 20	Year	0610 M
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of De	ath	4c. County	of Death	
		•	Memorial Ho	ospital		Eus	ton		T.	ALBO	T
81	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 H		h v, Year)	9. Birthp	lace (State or Foreign
4	Director		259-16-5513 1X	M 2□F 89	Yrs.	Months Days		12-02-	1918	Gá	* *
	pu ,		Usual Residence of Decedent  10a, State 10b, County	10c City	, Town or Lo	cation	-		- 49	1	0d. Inside City Limits
	aryla shov	<u> </u>			,						1 □Yes 2 No
	the M 28a-f iotific	Director	Md. Caroline  10e. Street and Number	Pre	eston	10f. Zip Code			10g. Citizen of N	What Cour	
	with a or			n Drive		· ·	CEE				•
	eath ns 23 musi	era		2. Was Decedent Ever in U.	S. 13. 1		655 lispanic Origin?	(Specify Yes or No- erto Rican, etc.)	USA 14. Rad	ce - Americ	can Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	ŀ	f Yes, specify Cub 1 □ Yes 2☑ No	ari, Mexicari, Pu Specify:	érto Rican, etc.)	Specif.		
8	thour atura	ed	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occup	ation		16b. Kind of B		Black
7	nin 72 in "in Medii	Completed	(Specify only highest grade	College (1-4or 5+)	(Give life. I	kind of work done DO NOT use retire	during most of v d)	vorking	John	N. W	Tright
212	d with giene er tha the I	E	1		Mac	nine Ope			Fact		
פ	e filed al Hygi other vent, ti	Be	17. Father's Name (First, Middle, Last)			_	18. Mother's N	lame (First, Middle,	Maiden Surnar	ne)	
<u>a</u>	12 should be filed w h and Mental Hygie 7 <b>Is marked other</b> tr raumatic event, th	ဥ	George Cobb,S	r.			Laura		Richard		
a	2 sho and Is ma		19a. Informant's Name/Relationship (Typ			-		Rural Route Number			
2 (i)	1 and 2 Health em 27 l		Bernitta Deshie			30 West	view Di	r. Prest	20c. Location		
Baltimore, Maryland 21215-0036	Pages 1 nent of 1- int: If Ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R	emoval from State	emetery, crei	natory or other pla				•	<i>'</i>
Ħ	t. Pa rtmer rtant: njury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fun  Service License		_			2-21-08			
Ba	permit. Page Department of Important: If any Injury or once.		21. rigitature of Full Service License	Froke				Easton			al Home
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the deat e cause on each line.	h. Do not ent	er the mode of dyi	ng, such as card	liac or respiratory a	rrest,		Approximate Interval Between Onset and Death
8	Physician		Immediate Cause (Final disease or condition	Pneumn	nia						
	/Medical Examiner		resulting in death)	Due to (or as a conseq	A 1	F. J.					
		ايا	Sequentially list conditions,	Due to for as a consecu	Renal	Failure	٠			-	
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D. 1.	mia	,					
	execution and al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq							
8760,	cate be executed oblysician and the burial-transit	dical									
မ	ifficate g phys as the	edi			-						
Вох	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	il death 3	⊒Ectopic pregnanc □ Other (specify) _	у			ate of deliv	ery Day Year
P. 0.	that the		Part II. Other significant conditions cor	stributing to death but not res	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did 1	tobacco use cor	ntribute to	the cause of death?
ds,	signe d be	d by						1 🗆	Yes 2 □ No	3□ Pro	bably 4 Onknown
Ö	w req	Completed		-				24a. Was	an 24b.	. Were aut	opsy findings available
Re	he lav e has ige 2	ш						— auto perfo 1□ Yes	psy ormed2 2 No	prior to co death? 1 \( \subseteq \text{Yes}	ompletion of cause of
ta	in: T tiflicat or, pa		25. Was case referred to medical				26. Place of I	Death Check onl		1 🗆 163	2 140
>	/slcia	To Be	eyaminer?	lospital: 1 [ Inpatient 2 ]	ER/Outpatie	nt 3 DOA Ot	hor:	g Home 5 ☐ Resi		ther (Speci	ify)
0	g Phy ter thi		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Inju	iry at	28d. Describe	how injury occu	irred	
Ö	ath. or: Aft	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Workin, Day Youn)	,,		Yes 2 □ No				
Division or Vital Records,	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Special	ome, farm, st	reet, factory, office			'Street and Num wn, State)	ber or Rui	ral Route Number,
Ω	vital o Ins aff Iral D						daka and al	and due to the	(a) and m		ototod
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier  (Check only one)  1 Certifying Physical Examination (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	ation and/or in	nvestigation, in my	opinion, death o	occurred at the time	, date and place	, and due	to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier			29c. Licen		_	29d. Date sign		
			the what	10 mm	20.	HOO	5377	5	Feb 19	,201	3 (
•	141		30. Name and address of person who co	omp eted cause of death (Iter	n 23a) (Type	Print)	54 1	100 100	1 2160	7/	
		The second	Faith Jabers - Mat	32 Aegistrar's Signa	ature		51. Ch	stm, mi	0 2100		
	Sta Regist		31. Date filed (Month, Day, Year) FEB 2 1 20	08 Secur )	K A	and i					
					-7	- 419					

**Examiner** law requires that the death certificate be executed and burial-tra Division or Vital Records, P.O. Box 68760, the attending physician the as signed by has been certificate Attending Physician: this After death.

Baltimore, Maryland 21215-0036

page 2 should be funeral director, after death the filled in by 24 hours

Certification: To Medical

2 Accident

3

within 24 the

completely

ö

28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0031173 02/26/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nelson, M.D. 1160 Varnum St., N.E. # 208, Washington, D.C. 20017 Raymon

31. Date filed (Month, Day, Year) 2008 32. Registrar's Signatu

State

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Claudette A. Diggs February 23. 1:20 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Casey House Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 😾 F Months Hours Director 71 250-68-6688 July 27, 1936 Nesmith, Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20906 Funeral 3310 North Leisure World Blvd. #226 U.S. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Specify: African Maryland 21215-0036 1 ☐ Yes 2 ☑ No δ 3 Widowed 4 □ Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 4 Computer Programmer TBM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental marked Claudia Sharperson James W. Barr and N 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If Item 27 is any Injury or other trains 2651 Spruce St., Denver, CO 80238 Gregory A. Diggs / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 Donation 5 Other (Specify) 3/2/2008 Parham Cemeterv Martin, TN 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. Hompso 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Libease or highr) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed physician and s the burlal-trans Due to (or as a consequence of) P.O. Box 68760 Physician/Medical as 1 attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t lirector, page 2 s autopsy performed? 2 🔯 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \square$ Other (Specify)  $\bigcirc$  Hospice 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 NNatural 5 Pending investigation To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Genevieve Wroblewski 6001 Muncaster Mill Rd. Rockville, MD 20855 31. Date filed (Month, Day, Year) FEB 2 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and title of certifie

29b. Signature

Registrar's Signature

0)

29c. License number

D0064615

29d. Date signed (Month, Day, Year)

February 25, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2008 FEBRUARY 9:40AM M MARY E. DUNN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT EASTON WILLIAM HILL MANOR If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours 1□M 2√2F 91 Yrs. 215-09-8101 MARYLAND Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 □ No Completed by Funeral Director EASTON TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 DUTCHMANS LANE 21601 UŞA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ 2 X No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 K No Specify: Specify: 3 ¥ Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 11 **CLERK** MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN K. CAULK, JR. LENA LAMDIN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPHINE C. DAWSON/SISTER 28266 ISLAND CREEK RD., TRAPPE, MD 21673 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 2/27/2008 STEVENSVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

at enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Closeph M. Esthwich C.F.S. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final dio seconse disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to o as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Part IJ: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 ☐ No Certification: To 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) D08715 William Dog 30. Name and address of person who completed cause of death (Item-23a) (Type, Print) WILLIAM H. WOOD, JR. M.D. 501 DUTCHMANS LANE, EASTON, MD 21601 31. Date filed (Month, Day, Year) State

Registrar DHMH 17 Rev 1/2001

**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28e-f show other treumatic event, the Madical Examiner must be notified at

al Hygiene.

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Pages 1 end 2 siment of Health an ant: If item 27 is:

permit. Pages Department of Important: If it any injury or o

**Physician** 

/Medical

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Funerel Director: A

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Hospitel or Attending

Examiner

The law requires that the death certificate be executed

P.O.

Division of Vital Records,

iled within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

7

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 12:42 P M Joy Ann D'Agnenica FEBRUARY 25, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PLATA MEDICAL CHARLES CIVISTA CFNTER LA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 16,1943 Birthplace (State or Foreign Country) **Funeral** 6. Sex 1 M 2 F Months Days Hours Washington, D.C Director 213-42-5398 64 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits notified at 1X Yes 2 No Directo Maryland Charles 28a-f Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be permit. Pages 1 and 2 should be filed within 72 hours after death will Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a is any Injury or other traumatic event, the Medical Examiner must by once. 3413 White Fir Court, Unit C Funeral 20602 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White Completed by 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Elsie Marie King Poland Gilmer Walter Poland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carroll M. D'Agnenica/ Husband 3413 White Fir Court, Unit C, Waldorf, MD, 20602 of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) rematory Feb. 27, 2008 Waldorf, Maryland 22. Name and Address of Facility Huntt Funeral Home Huntt Crematory 21. Signature of Funeral Service Licensee MOIZEZ 3035 Old Washington Rd. Waldorf, Maryland, 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** sertan disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-trans Stople Due to (or as a consequence of) Physician/Medical as use IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hasr autopsy performed? Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient ဥ 1 ☐ Yes 2 ER/Outpatient 3 DOA 27. Manner of Leath 1/2 Natural 2 ☐ Accident Date of Injury 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: (Month, Day Year) Injury 5 Pending

P.O. Box 68760 Division or Vital Records, After this To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

State Registrar

Medical

ROSEMARY IWUNZE 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

investigation 6 Could not be determined

of person who con

2008

701 EAST CHARLES ST. LA PLATA , MD

32. Registrar's Signature

pleted cause of death (Item 28a) (Type, Print)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D-05550

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

20646

 $^{\rm Amend}$   $^{\#1}$  , per MD G884 10/29/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) Stephen Fairbank Davis, Jr. 2. Date of Death 3. Time of Death Month FEB 23 2008 **Physician** STEPHEN FAIRBANKS DAVIS, JR 3:01 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 10, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1⊠M 2□F 1960 Pennsylvania 486-66-2136 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Woodbridge V٨ Fairfax 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 22191 2795 Burrough Hill Lane by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 凶Yes 2 □ No If Yes, Give Year or Dates:1982-2008 1 ☐ Never Married 2 Married white 1 ☐ Yes 2 🖾 No Specify Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) U.S. Navy Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jane Harreld Stephen F. Davis, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2795 Burrough Hill Lane, Woodbridge, VA 22191 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trac Wynne Davis (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Falls Church, VA National Crematory 02-29-2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Demaine Funeral Home 21. Signature of Funda Service License 5308 Backlick Rd, Springfield, VA 22151 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MEDULLARY THYROID CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy perform Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 🔀 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

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The law requires that the death certificate be executed

or Attending Physician:

Division or Vital Records, P.O. Box 68760,

the Maryland

"natural", or items 23a or 28a-f show edical Examiner must be notified at

and 2 should be filed within 72 hours after death with meath and Mental Hyglene. Az 15 marked other than "natural", or items 23a or : mer traumatic event, the Medical Examiner must be a fine traumatic event, the Medical Examiner must be a fine traumatic event, and the modifical examiner must be a fine traumatic event, and the modifical examiner must be a fine traumatic event.

Baltimore, Maryland 21215-0036

ate has been signed page 2 should be det after death.

I Director: A

ed in by the fu

2 Medical Certification:

27. Manner of Death

5 Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28c. Injury at Work?

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

(Check only one)

1X Natural

2 Accident

4 Homicide

3 ☐ Suicide

1 Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier

A88449 (CA)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARISELA M. NOORHASAN

NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

State Registrar 31. Date filed (Month, Day, Year) FEB 2 9

LT MC32. Registrar's Signature

within 24 hours a

To the Funeral I

completely filled

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# layden Lith Jewel Farmer Baltimore, Maryland 21215-0036

P.O. Box 68760,
Records,
f Vital
Division o

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** 212008 0121 JAYDEN LILITH JEWEL FARMER ebruary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Memorial Hosp. at albot aston 8. Date of Birth (Month, Day, Year) 6. Sev If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min 38 Months Days Hours 1 ☐ M 2 🗷 F Yrs. Director MARYLAND FEB 21, 2008 Usual Residence of Decedent the Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No MD DORCHESTER SECRETARY Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 116 ACADEMY STREET 21664 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 5 1 ☐ Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced al Hygiene.
d other then "natural event, the Medical E "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JONATHAN MATTHEW FARMER JESSICA ROSE FASSETT ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 116 ACADEMY ST., SECRETARY MD 21664 JONATHAN FARMER/FATHER 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION CTR 2/25/2008 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA MERCERO 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Extreme disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): physician Physician/Medical the attending p for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) bed 1 the 9□ Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' certificate 1 ∐ Yes 1 ☐ Yes 2 ☐ No 2/2/No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 3 DOA this s after death.
Il Diractor: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by determined 4 Thomicide To the Hospital within 24 hours a To the Funaral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number 1)5850 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Easton Maryland 21601 Michael Jidd. M.D. Easton Memorial He DITAL 31. Date filed (Month, Day, Year) egistrar's Signature State **FEB 25** 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 26, 2008 11:33 A M KATHRYN GARDNER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 7-19-1917 9. Birthplace (State or Foreign 6 Sex **Funeral** Country)
Washington DC Days Hours 1 □ M 2 🖺 F 90 577-14-9518 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Directo DCWashington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20010 3200 16th St NW UNITED STATES Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status XXNever Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than College (1-4or 5+) PRivate Data Entry Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Gardner Bessie Anderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1629 Columbia Rd NW #806 WashingtonDC 20009 Reginald Lee White/Son other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Metropolitan Crematory 2-29-2008 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ò permit. Page Department of Important: If any injury or once. 4 Donation 5 Dother (Specify) Alexandria VA Signature of Funeral Service Licens 22. Name and Address of Facility Washington DC 20020 Pope Funeral Home 2617 Penn Ave SE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autonsy autopsy performed? /es 2🗷 No 1 ☐ Yes 2 No 1⊟ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To. Hospital 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation Injury 1 X Natural To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month Day Year) FEB 2 9 Registrar

7325A HANOVERPARKWAY

who completed cause of death (Item 23a) (Type, Print)

GREENBELT MARTLAND 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5 Mercand Attorney, G891 5/27/09 TT

			For State Registrar	State of Marylan	-	ärtment of F rtificate of I		-	giene <sub>Reg. No.</sub> 2 (	008	08068
	Physici /Medic		1. Decedent's Name (First, Middle, La Sherrill Harkins					2. Date of De Month Febru	Dav	, Year 2008	3. Time of Death 3 12:26 a <sup>M</sup>
	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	r Location of Death		4c. Coun	ty of Death	
	Funeral Director	#X!			last birthday) Yrs.	Rocky If Under 1 Year Months Days	ille If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Aug. 10	th y, Yea <i>r)</i>	ontgom 9. Birthpl Count Penns	nery ace (State or Foreign try) Sylvania
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation	<u> </u>			10	Od. Inside City Limits
	a-f sh	ctor	Maryland N	Montgomery	Roo	ckville					1 ∐Yes 2 <b>√⊡</b> No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	try?
	s 23a	ıral	1433 Fallsmead W			20854				SA	- Indian
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	.5. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Ispanic Origin? (Span, Mexican, Puerto Specify:	ecity Yes of No Rican, etc.)	Bi	ace - America ack, White, e aify: Whit	etc.
21215-0	/ithin 72 ho ne. han "natur e Medical 8	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ade completed)  College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of worl d)	king	16b. Kind of		lustry
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Maryland	ould be i Mental I arked or atic eve	To Be	Robert Archibald				Ludmillie			,	
ary	should Ind Men marke	Ě	19a. Informant's Name/Relationship (		19b. Maili	ng Address (Street				n, State, Zip	Code)
	1 and 2 Health a em 27 is		J. Parker Griffin	, III/Son	14:	33 Fallsm	ead Way,	Rockvil	le, MD	20854	:
Baltimore,	Pages 1 ament of He ant: If Item ury or oth		20a. Method of Disposition  1	Removal from State	cemetery, cre	osition (Name of matory or other place Memorial	1	ch 1, 2008	20c. Location	•	wn, State Maryland
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lice	Color	]	2. Name and Addre Francis J	<ul> <li>Collins</li> </ul>				
Division or Vital Records, P.O. Box 68760, Tonian	The law requires that the death certificate be executed <b>EXAMPLY</b> The law requires that the death certificate be executed to the attending physician and be detached for use as the burial-transit and all all and al	l Examiner	23a. Part1. Enter the disease, or comphock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.	th. Do not en						g, MD 2090 Approximate Interval Between Onset and Death
		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of α	al death 3	□Ectopic pregnanc □ Other (specify) _	у				Day Year
		by	Part II. Other significant conditions	contributing to death but not res	sulting in the (	ınderlying cause giv	ren in Part I.		tobacco use co		ne cause of death?
		Completed						24a. Was	an 241	b. Were autoprior to condeath?	psy findings available inpletion of cause of
	ysician: The is certificate hadirector, page	Be (	25. Was case referred to medical examiner?	Harrist N. J.			26. Place of Dea				
		은	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatie	nt 3 DOA Oth	4 □ Nursing H	ome 5 Res	idence 6 C		y)
	or Attending uter death. Director: After in by the fune	Certification:	1 Natural 5 Pending investigatio 2 Accident 3 Suicide 6 Could not be determined	(Month, Day Year)	Injury nome, farm, st	M 1	yat k? Yes 2 □ No	28f. Location			al Route Number,
_	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier (Check only one)  Certifying P  Certifying P	hysician: To the best of my known in the basis of examinating and manner stated.	owledge, dea ation and/or i	th occurred at the tinvestigation, in my	me, date and place opinion, death occu	e, and due to the urred at the time	e cause(s) and , date and plac	manner as sie, and due to	tated. the cause(s)
	within 10 th	Me	29b. Signature and title of certifier  Wexard	a Mulan	ule n	29c. Licens 10 006	se number SS19		29d. Date sig	-20	Day, Year)
	•		30. Name and address of person who Alexander Mula	amula, MD 9	901 Me	dical Cen	ter Drive	e, Rock	ville,	MD 208	350
Ì	Sta Registi		31. Date filed (Month, Day, Year) FEB 2 8 20	32 Registrar's Sign	ature	ale					

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Death Decedent's Name (First, Middle, Last) Patricia Lou Hammond March 03 2008 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Washsington Reeders Nursing Home Boonsboro If Under 1 Year | If Under 24 Hrs. Social Security Number 317–26–1196 7. Age (In yrs. last birthday) 81 Yrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Days Hours Min. 1 ☐ M 2 🔀 F 01/02/1927 IN Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State MD Washington Hagerstown 1 ☐ Yes 2X No 10g. Citizen of What Country? 10f. Zip Code 21742 10e. Street and Number 11557 Robinwood Drive, Apt. 10 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify. 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Government Receptionist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edith Bushong Glenn Stookey 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9955 Kurtyka Circle, Hagerstown, MD 21740 Brent L. Hammond / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 03/04/2008 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CEREBRO VILLUM ALURE month Due to (or as a consequence of) ANUANCED EM ENTITY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) MULTISYS TEM Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? death? 1 ☐ Yes 2 No 2 ☐ No

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar and physician s the burial attending ph for use as t signed by the a

Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Physician

/Medical

Examiner

**Funeral** 

Director

Department of Health and Mental Hygiene. Important; if items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than Medical Examiner must be notified at once.

72 hours after

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Pages 1

Maryland

Baltimor

Funeral

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Completed

Be

Examiner Physician/Medical Be Completed by Certification: To

25. Was case refer examiner?		26. Place of Death (Check only one)								
1 Yes 2	No	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3 🗆 1	DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)				
27. Manner of Deat  1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation		28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred				
3□ Suicide 4□Homicide	6 Could not be determined		- At home, farm, stree Specify)	et, fact	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier	1 PCertifying Ph	nysician: To the best of m	ny knowledge, death	occurr	ed at the time, date and pla	ce, and due to the cause(s) and manner as stated.				

200.	(Check only one)
206	Claneture

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 146561

2008

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lapans Rd Boonsboro, MD 21713 (301) 432 8470 Dr. Ghazala Qadir 20311 31. Date filed (Month, Day, Year)

State Registrar

MAR 0 4 2008



neral Director: /

Medical

within 24 hours at to the Funeral C

			For State	State	of Marylan	-	artment of H				08 08070			
	1. Decedent's Name (First, Middle, Last)								Reg. No. 2. Date of Death 3. Time of Dea					
Γ,	Physicia	an									14 11			
	/Medical Helen Catherine HOOVER						4b City Town or	r Location of Death	Hewivar	February 28 208 3:4				
Examiner 4a. Facility Name (If not institution, give street and number)														
	Funeral		Washington Cot 5. Social Security Number	unty Hosp 6. Sex	7. Age (In yrs.	last birthday)	Hager:	If Under 24 Hrs.	8. Date of Birth		ington 9. Birthplace (State or Foreign			
н	Director		216-22-9721	1 □ M 2 <b>X</b> ) F	80	Yrs.	Months Days	Hours Min.	(Month, Day, 1) May 27 1		Country) Pennsylvania			
			Usual Residence of Decedent						1147 27 1	721 11	· · · · · · · · · · · · · · · · · · ·			
	rylan how		10a. State 10b. County	1	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits			
	e Ma 3a-f s	양	W. VA. Berke	eley	Fa	1ling	Waters				1 ☐ Yes 21 No			
	or 28	Director	10e. Street and Number			_	10f. Zip Code		10	g. Citizen of Wh	at Country?			
	ath w		65 Bowie Drive				254			USA				
	hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notified at	Funeral	11. Marital Status	Armed I		.S.   13.	Was Decedent of H If Yes, specify Cuba	lispanic Ongin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, White, etc.			
36	s afte	by F	1 Mever Married 2 Mar 3 Widowed 4 Divorced	If Yes. (			1 ☐ Yes 2 X No	Specify:		Specify:	IIIb i to			
5-0036	hour tural al Ex			nt's Education	Dates.	16a, Dece	dent's Usual Occup	ation	1	6b. Kind of Busi	White iness/Industry			
Ž	in 72 n "na Nedic	olet	(Specify only highe	est grade completed		(Give	kind of work done DO NOT use retired	during most of work d)	king		,			
7	filed within 72 Hygiene. Ither than "nai Ithe Medica	Completed	Elementary/Secondary (0-12)  9	College	(1-4or 5+)		Driver			Flor:	ist			
D	illed Hygid other ent, tl	Be C	17. Father's Name (First, Middle,	, Last)				18. Mother's Nam	e (First, Middle, M					
a	should be filed within 72 hours after death with the Marylan of Mental Hygiene. marked other than "natural", or flems 23a or 28a-f show marked other than "natural", or flems 23a or 28a-f show marke event, the Medical Examiner must be notified at	To B	Frank Crell Ho	oover				Tsahe11	e Schloti	t Kneis	1ev			
Maryland 2121	G 60 3	-	19a. Informant's Name/Relations			19b. Maili	ng Address (Street							
	ages 1 and 2 should nt of Health and Mer : If Item 27 is marke or other traumatic		Wynona M. Dav:	is - Exec	utrix	768 E	Broad Lane	e. Fallin	g Waters	. West V	Virginia 25419			
more,	of He		20a. Method of Disposition		20b. i	Place of Dispo cemetery, cre	osition (Name of matory or other place	ce)	Date 2	0c. Location - C	ity or Town, State			
E	Pages nent of I int: If Its iry or o		1XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3		III State		1 Cemete		08	Hageret	own. Marvland			
a	permit. Pag Department Important: I any Injury o		21. Signature of Europeal Service	Licensee	11		2. Name and Addre	an of Facility.	Minnich 1					
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9			IF FEMALE:	00. 14										
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<u>.</u>	ie de the a hed fi	Physician/Me	1 □ Yes 2 □ No 9 □ Unknown 5 □ Other (specify) 9 □ Unknown											
σ.	The law requires that the death certificate has been signed by the attending proage 2 should be detached for use as	Ph	Part II. Other significant condit	dons contributing to	death but not res	sulting in the u	underfying cause giv	ven in Part I.	23e. Did tob	acco use contrib	bute to the cause of death?			
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Ö	requ	etec	0.77	., ., .	-	1			04-144					
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Division or Vital Records, P.O. Box	Attending Physician: r death. ector: After this certifics by the funeral director. I	Be	25. Was case referred to medic examiner?	Hospital:		7==10	int 3CLDOA Oth	ner-	th (Check only one					
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S	deatl deatl ctor: y the	ical	3 Suicide 6 Could	not be 28e. Pla	ace of injury - At h	l nome, farm, si	treet, factory, office		28f. Location (Str	reet and Numbe	r or Rural Route Number,			
<u>S</u>	after Dire	Certification:	4 ☐ Homicide determ	bu bu	ilding, etc. (Spec	ify)			City or Town	City or Town, State)				
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as			ing Physician: To										
	n 24 }	Medical	(Check only 2 Medics one)		e basis of examin nanner stated.	ation and/or i	nvestigation, in my	opinion, death occu	irred at the time, da	ate and place, a	nd due to the cause(s)			
	To the Ho within 24 I To the Fu completel	ž	29b. Signature and title of certifi	er			29c. Licens		25		(Month, Day, Year)			
٧.	18		V4 dll 8 0	March 1	b).		02	3815		22	9-08			
0	DIP		30. Name and address of perso											
	ľ		Dr. Mary Mon					d. 21740						
		ate	31. Date filed (MMARey, Oea	3 2008 32	egistrar's Sign	nature	house							
	Regist	rar			Viete and	-								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 23, John Edward Herring **Physician** February 2008 9:55 p M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Olney Montgomery General Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 MM 2□ F 578-05-6558 DC Washington, Director 5, 1918 Feb. Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Spring Maryland Montgomery Silver 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20906 3700 International Drive Funeral death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ∏ Yes 2 XXIIIo Specifiwhite Specify. þ 3 Midowed 4 □ Divorced Year or Dates: WWIT Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If Item 27 is marked other thrany or other traumatic event, the 5+ Budget Federal Government Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecelia E. Beckley George Edward Herring 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9900 Cherry Tree Lane, Silver Spring, MD 20901 Margaret H. Mulligan/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 29 Feb. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 \$ilver Spring, Maryland 21. Signature of Funeral Se 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. vice License 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or com licat shock, or heart failure. List only o e o Approximate Interval Between ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Tiv Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed inax burial-tran and Due to (or as a consequence Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical as the l IF FEMALE use 23c. If ves. outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 Fetal death 3 ☐Ectopic pregnancy Por Month in the past 12 months? Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the detached 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> g 4 Onknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s has autopsy performe certificate 1□ Yes 2 No Physician: after death.

Director: After this certific 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Inpatient 2 ER/Outpatient 3 DOA P 1 ☐ Yes Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury (Month, Day Year) Hospital or Attending 1 Natural 5 ☐ Pending investigation М 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral DI completely filled in recritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

State

29b. Signature/and title of certifier

31. Date filed (Month, Day, Year)

0

28

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hanc

Mont

Redistrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

DINEYMD 20832

Devoted the Name (First, Middle, Last)   Charlotte Louise Henderson   Devoted Observation (Page 25)   St. 40		1 - For State Registrar	State of Maryland		of Health and N	Mental Hygie	_	08072	
## Facility Name (if not Institution, give street and number) ## Holy Cross Hospital    Social Security Number   Social S			•	enderson		Month		3. Time of Death 5:40a M	
218-16-0168		Holy Cross Ho	spital	Sil	ver Sprin	g	Montgom	nery	
10a. State months of the state		218-16-0168		Months D		8. Date of Birth (Month, Day, Y 9 / 26 / 1	9 Birth 923 Was	place (State or Foreign Intry) h., D.C.	
23a. Part . Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Betwee Onset and Dei Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  Present and Dei Or as a consequence of):  Due to (or as a consequence of):  Due	ried at	10a. State 10b. County			ng			10d. Inside City Limits 1 ☐ Yes 2 💆 No	
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Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  Proposed and Definal disease or conditions resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Understand  Due to (or as a consequence of):  D	Depart import any in once,	I Nkily D trus	/L	9241 C	olumbia B	lvd.Silv	er Sprin	E,P.A. 19,Md20910	
Due to (or as a consequence of):  Pneumonia  Due to (or as a consequence of):  Pneumonia  Due to (or as a consequence of):  Pneumonia  Due to (or as a consequence of):  Due to (or as a consequence of):		Immediate Cause (Final disease or condition			f dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death	
That initiated evertis resulting in death) Last    Due to (or as a consequence of):	aminer		<sub>b.</sub> Pneumonia						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I.  1   Yes 2   No 3   Probably 4   University   Variable   Variabl	cian and burial-transit I Examine	that initiated events	c						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I.  1   Yes 2   No 3   Probably 4   University   Variable   Variabl	ng physic s as the b Medica	IF FEMALE:	<b>a</b> , d						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I.  1   Yes 2   No 3   Probably 4   University   Variable   Variabl	si sed	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🖾 No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)							
2 9 2   76	be d	Part II. Other significant conditions	contributing to death but not resulti	ng in the underlying caus	e given in Part I.				
	ate has page 2					autopsy performe	prior to death?	completion of cause of	
25. Was case referred to medical examiner?  1	director,	examiner?	Hospital: 1 X Inpatient 2 ☐ EF	R/Outpatient 3 DOA	Other			cify)	
25. Was case referred to medical examiner?  1	or: After the funeral	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)			28d. Describe how	injury occurred		
28a. Date of injury at Work?  1 Natural 5 Pending investigation 3 Suicide 4 Homicide 5 Could not be determined 5 Pending investigation 5 Pending investigation 6 Could not be determined 5 Pending investigation 6 Could not be determined 5 Pending investigation 6 Could not be determined 5 Pending investigation 6 Pending	irs after de rai Direct lled in by t Certific	4 ☐ Homicide determined	building, etc. (Specify)			Cify or Town,	State)		
25. Was case referred to medical examiner?  1   Yes   2X   No	thin 24 hou the Fune mpletely fill	(Check only 2 Medical Examone)	niner: On the basis of examinatio	n and/or investigation, in	my opinion, death occu	rred at the time, dat	e and place, and due	to the cause(s)	

Division or Vital Records, P.O. Box 68760,

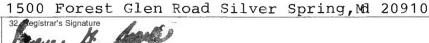
Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) FEB 2 8 2008

Maria Tayag M.D.

29b. Signature and title



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mn.



29c. License number

D63579

29d. Date signed (Month, Day, Year) 2 /2 6 / 2 0 0 8

State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 🦙 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 2\_ 845 PM Helen Hubert 2008 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltimore City If Under 1 Year | If Under 24 Hrs 5. Social Security Number 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Hours 1 M 2 T 114-09-6924 89 SEPT. 24,1918 NEW YORK Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show notified at 1**X**Yes 2 □ No Director MD TALBOT EASTON 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö Examiner must be 640 MECKLENBURG AVE., APT 104 23a 21601 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 No ö 3altimore, Maryland 21215-0036 Specify Completed by WHITE 3 X Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry r than College (1-4or 5+) al Hygiene. Elementary/Secondary (0-12) 0 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be if Health and Menta item 27 Is marked UNKNOWN THOMAS MARION UNKNOWN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 300 LAUREL ST., EASTON, MARYLAND 21601 GEORGE P. HUBERT/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot CHESAPEAKE CREMATION CTR 2/22/2008 STEVENSVILLE, MD 21. Signature Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** dortic stenosi unknown disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-tra Due to (or as a consequence of) attending physician for use as the buris Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe e 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 Yes 2 No 1☐ Yes 2 🔀 No or Attending Physician: ector, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ this funeral 28a. Date of Injury 28b. Time of 27 Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After 5 Pending investigation (Month, Day Year) Injury 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 1 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ress of person who completed cause of death (Item 23a) (Type, Print) Kimberly Lumpkins MD
31. Date filed (Month, Day, Year) S Greene St Baltimore MD 21201 State Registrar

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician 0339 M February 22 JANET W. HASCEK 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Easton Memorial Hospital If Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
OCT 20,1939 9. Birthplace (State or Foreign Country) **OHIO** 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2**X** F Director 68 217-40-7840 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director ROYAL OAK TALBOT MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or TISA 21662 6650 EDGE ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? or items 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes X☐ No Specify. Specify: WHITE þ 3 Widowed 4 Divorced "natural" Completed permit. Pages 1 and 2 should be filed within 72 hor Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur. any Injury or other traumattc event, the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HEALTHCARE X-RAY TECHNICIAN 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN WILLIAM WALSH ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO BOX 171, ROYAL OAK, MARYLAND 21662 ALFRED L. HASCEK/HUSBAND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEMORIAL PARK 2/28/2008 EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601 Joseph 21. Ostrowshi C.F.SP. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) asperation **Physician** Umunules /Medical Due to (or as a consequence of): promonay disease Examiner 15 Waks alstruture if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-transit Due to (or as a consequence of) ナス3 A しいivision or Vital Records, P.O. Box 68760, physician Physician/Medical as the t IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s certificate has performed' 25. Was case referred to medical examiner? Be ( 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 1 ☐ Yes 2 No 1 🔲 Inpatient e this funeral To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director; After it completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After t 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

29b. Signature and title of certifier

MITHEW

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FISCHER

and manner stated.

Martin Count

10

Hasce

anet

29c. License number

DSZ251

29d. Date signed (Month, Day, Year)

21501

108

		1	For State Registrar	State of Mary		artment of H rtificate of L			JIEΠE eg. No.? Π ∩ Ω	08075
a			1. Decedent's Name (First, Middle, La					Date of Dea     Month	th Day Year	3. Time of Death
	Physicia Medic/		Harry David Ho	olden, Jr.		T		Februar	y 26, 2008	12:00 PM
	Examin	er	4a. Facility Name (If not institution, giv				Location of Death		4c. County of Dea	atri
<u> </u>	Funeral		269 E1k View Road  5. Social Security Number 6. S	ex 7. Age (I	n yrs. last birthday)	North If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Q Rir	rthplace (State or Foreign ountry)
	Director		000 03 3100	M 2□F 8	6 Yrs.	Months Days				ermont
	land ow it	-	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	ocation		-		10d. Inside City Limits
	a-f sh	ģ	Maryland Cecil		North	East				1 ☐ Yes ATNo
	n with the	al Directo	10e. Street and Number 269 E1k View Road	l		10f. Zip Code	1901		10g. Citizen of What C United Sta	
920	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mertial Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical	by Funeral	11. Marital Status 1	12. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 ☐ No If ♣es, Give Year or Dates: US		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 A No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: W	
2-003p	72 hou	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	edent's Usual Occup e kind of work done of DO NOT use retired	ation during most of work	ding	16b. Kind of Business	s/Industry
7	within iene. than "	ldmo	Elementary/Secondary (0-12)	College (1-4or 5+)		nancial A			Financ	ial
D	il Hygid other ent, tl	Be Co	17. Father's Name (First, Middle, Las						Maiden Surname)	
ylan	2 should be and Mental is marked or raumatic ev	TOE	Harry D. Holder		1 -			te Clem		7:- 0:- 1:>
Nar	d 2 sho	6 0	19a. Informant's Name/Relationship						er, City or Town, State, t, Marylan	
<u>က်</u>	s 1 and f Health item 27 other tr		Mary M. Holden  20a. Method of Disposition			osition (Name of ematory or other place		Date cuary	20c. Location - City o	
Baltimor	Pages nent of I ant: If ite ury or o		1 ☐ Burial 2 🖾 Cremation 3 [ 4 ☐ Donation 5 ☐ Other ( <i>Sp</i> ec	JRemoval from State		e Cremato	1	-	Newark, De	laware
Salt	permit. Pag Department Important: any injury once.		21. Sign or 1 Fu I Se e lin	se		22. Name and Addre	0,		neral Home	
	20 = 6 0		23 . Part1. Enter the disease, o or shock, or heart failure. List of	applications that caused th						Approximate Interval Between
	Physician		Immediate Cause (Final	ne cause on each line.	0.9.					Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a c	consequence of):					9
	Examiner	_	Sequentially list conditions,	b. Due to (or as a c	consequence of):					
_	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	200 10 (01 00 0						
oʻ	e exect an and irial-tra	Exa	resulting in death) Last	Due to (or as a c	consequence of):					
98760	ficate be executed physician and sthe burial-transit	edical		d	<u> </u>					
O. Box 6	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	☐ Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of d Month	lelivery Day Year
ds, P.	ires that signed by I be deta	by	Part II. Other significant conditions	contributing to death but	not resulting in the		ven in Part I.	,	obacco use contribute Yes 2 ☐ No 3 ☐	to the cause of death?  Probably 4 Dinknown
Records,	w requ	Completed	- Cropp		1		0	24a. Was		autopsy findings available
	The la te has	omp						autoj perfo 1∐ Yes	ormed?   prior to death	
Ita	clan: ertifica etor, p	Be C	25. Was case referred to medical examiner?	I to a feet		04	26. Place of Dea	No. of the last		
٥. د	Physical this carral direction	은	1 ☐ Yes 2 No 27. Manger of Peath	Hospital: 1 ☐ Inpatient	2 ER/Outpation	BIIL SU DOA			dence 6 Other (S)	pecify)
O	nding th. : After e funer	rtion	1 Natural 5 Pending 2 Accident investigati	(Month, Day 1	<i>Year)</i> Injury		rḱ? ]Yes 2 □ No			
Division or	or Atter fter dea Director in by the	Certification:	3 Suicide 6 Could not 4 Homicide determine		/ - At home, farm, s (Specify)	street, factory, office		28f. Location ( City or To	Street and Number or wn, State)	Rural Route Number,
	Hospital 24 hours a Funeral I rtely filled	Medical Ce	29a. Certifier (Check only one)  Certifying I	Physician: To the best of aminer: On the basis of e	xamination and/or	ath occurred at the t investigation, in my	ime, date and place opinion, death occ	l e, and due to the urred at the time,	cause(s) and manner date and place, and c	as stated. due to the cause(s)
	Fo the vithin 2 Fo the comple	Med	29b. Signature and title of certifier	With marrier state		l l	se number		29d. Date signed (Mo	
)	, ,,,		) Cural &	1. Stoog	for ms.	D)	8628		2/26	108
	12111		30. Name and address of person wh	completed cause of lea	ath (Item 23a) (Type	e, Print)	Baila	CL 51	Kton MS	108
	15 →   VA St	ate	31. Date filed (Month, Day, Year)	2000 S2. Redistrar	's Signature	1. 4.	. 10 rage	5/ 21	/ 5 / 10	, , , , , , ,
	Regist	rar	FEB 2 7	2008	w Dr /	green				

			1 - For State Registrar	tate of Ma	aryland		rtment of H		nd Menta		ene 0 0	8	08076
			Decedent's Name (First, Middle, Last)						2. Date Mor	e of Death	Day	Year _	3. Time of Death
ı	Physici /Medic		Aidah Aseelah Jaami						Mol		ૐ ે	8	10:00V W
	Examir		4a. Facility Name (If not institution, give stre	et and number)			4b. City, Town, or	Location of	Death		4c. County	ol Death	
		<u>ps</u>	Prince George's Hos				Chever1	If Under 2	Id Hea I a		Prince		
В	<ul><li>Funeral</li><li>Director</li></ul>		5. Social Security Number 6. Sex 1 M	<b>2</b> ₹□ F 7. Ag	e ( <i>in yr</i> s. i. 81	ast birthday) Yrs.	Months Days	Hours	Min. (Mo	e of Birth nth, Day, Y 23	1926	9. Birthp Coun	
	ס		Usual Residence of Decedent		01				rinit,	. 209	1720	71141	) Gill C
	rylan		10a. State 10b. County		10c. City	, Town or Lo	cation					1	0d. Inside City Limits 1 X Yes 2 No
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	with th	Die.	10e. Street and Number				10f. Zip Code			-	. Citizen of W		,
	eath va 234	erai	3820 Hayes Street N	E #4 Was Decedent	Ever in U	S 13 V	20019 Was Decedent of Hi	snanic Orio	in? (Specify Ye		nited S		ean Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or itema 23e or 28e-f show any injury or other traumatic event, the Mcdral Examiner must be multiled at ODCe.	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 2  If Yes, Give Year or Dates:			Yes, specify Cuba	Specify:	Puerto Rican, e	etc.)		c, White,	etc.
Ö	2 hou	ted	15. Decedent's Educati				leni's Usual Occupa		of working	16	b. Kind of Bu		
215	thin 7	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. I	kind of work done of OO NOT use retired,	u <i>ring m</i> ost )	or working				
7	ed wil	5	UNK			Nurse	's Aid				Medica.		
and	be fill stal H d off	Be	17. Father's Name (First, Middle, Last)						's Name (First,	Middle, Ma	uden Sumam	∍)	
ž	hould d Mer mark matic	၉	Edmond King  19a. Informant's Name/Relationship (Type,	Print)		19h Mailin	g Address (Street a	Annal		Number (	City or Town	State Zin	Codel
<u>8</u>	od 2 s Ith an 27 is trau		Kim Toney, Grand Da			1.353	First St	reet :	SW	740111007,	ony or rown,	J.1210, 27p	, 0000)
ē,	s 1 ar f Hea item		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other place	1	Date	7 20	c. Location -	City or To	own, State
Ë	Page: ent of nt: if ry or		1 X Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State			National	1	FEB. 27	-	aurel,	Mars	v1 and
Baltimore, Maryland 21215-0036	partm porta y inju		21. Signature of Funeral Service Licensee			22	. Name and Addres	s of Facility	,				
<u> </u>	88 28		Frum M. M.	-	M0150	8 9	ibadeau 1 33 Gist A	Mortu.	ary Serv LL, Silv	vice, ver S	P.A. pring,	MD 2	20910
			23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of	ions that caused ause on each li	the death	. Do not ent	er the mode of dying	g, such as o	cardiac or respir	atory arres	t,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Forta			nnia						
	Examiner			Due to (or as	a consequ	ience off;							
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	ience ol):							
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
Ó	sician and burial-transit	Еха	resulting in death) Last	Due to (or as	a consequ	ience ol):							
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai	d										
9	entific ling p	Med	IF FEMALE:	16	-1								
Вох	leath certific attending p	Physician/Me	in the past 12 months?	If yes, outcome  1 Live birth  4 Pregnant at	2 Fetal	death 3	Ectopic pregnancy Other (specify)				23d. Date Mor		ery Day Year
o	that the de led by the a detached f	ysic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9 Unknown	tillie of de	salli SE	Other (specify)						
Δ.	res that igned by be deta	by Ph	Part II. Dther significant conditions contrib	uting to death b	ut not resu	ulting in the u	nderlying cause give	n in Part I.	23	e. Did toba	cco use contr	ibute to th	he cause of death?
rds	quires in sigi	q p								1 🗌 Yes	2 🗆 No	3 Prob	pably 4 Unknown
ပ္က	aw requir is been si 2 should	piet							24	a. Was an autopsy	24b. V	Vere aulo	ppsy lindings available mpletion of cause of
ž	The lavele has page 2	Completed					•		10	perform	ed?	eath?	2 No
ita	ysician: The lis certificete hadirector, page	Be (	25. Was case referred to medical examiner?					26. Place	of Death (Chec	k only one			
5	Physi this c al dire	၉	1 ☐ Yes 2 → No	Inpatie	ent 2 🗆 I	ER/Outpatien		4 🗀 1901	sing Home 5	-			(y)
5	Jing F	lon:		28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	Work	rat ≀? Yes 2.∐N		scribe now	injury occurr	90	
Division of Vital Records,	Attending Physician: or death. ector: After this certifice by the funeral director; g	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Ini	urv - At ho	me larm str	eet, lactory, office	163 2		cation (Stre	et and Numb	er or Rura	al Route Number,
<u> </u>	- 8	Certification:	4 Homicide determined	building, et	c. (Specify	)	301, 740101 ), 530		City	y or Tòwn,	State)		
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) Certifying Physici		f examinat								
	To th within To the	Me	29b. Signature and title of certifier				29c. License	number		290	d. Date signed	(Month,	Day, Year)
-			WHIT	<b>NA</b>			DSJ	220		-	0/23/	2006	B.
				leted cause of d	leath (Item	23a) (Type,	Print) HOSP		^		1 - 1		- ^-
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(A)	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 8 2008	32 Registr	ars Signal	ure A	ales)						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month Year **Physician** 11:50 AM 24 2008 Kastantin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6760 Royal Oak
If Under 1 Year | If Under 24 Hrs. Talbot Thorneton Kd. 8. Date of Birth (Month, Day, Year) 2/20/1943 Social Security Number . Age (In yrs. last birthday) ce (State or Foreign **Funeral** Hours Days 1 M 2□ F 165-34-725 65 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 No LNDTalbot Funeral Director Royal Oak 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Industrial, or items 23a or important: If Item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a one. USA 2160 6760 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) aw torney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6760 Thorneton Rd. Rayal Kastantin Oak, mp 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 2-25-2008 Hanover, MD 22. Name and Ad ress of acility Anatomy Gifts Registry Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 7522 Connelley Dr. Suite P Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ancrea one year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. It is a light of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): the burial-Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: ed by the attendin detached for use . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1☐ Yes 2 No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 1 🔲 Inpatient 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title or certifie 29c. License number 29d, Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

Dr. Easton, MD 21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Teffrey Denton, M.D. 555 Cyniwcoch

FEB 2 5 2008

SIMBO

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar			01410 01		Cei	tificate of	Death	R	Reg. No.			
			Decedent's Nan	ne (First, Midd.	le, Last)	)					2. Date of Dea Month		Year	3. Time of D	Death
	Physici /Medic				L	illian	Agnes	Loomis			March	6	2008	2325	$P^{M}$
	Examin	4950	4a. Fecility Name	(If not institutio	n, give :	street and num	ber)		4b. City, Town, o	r Location of Deat	h	4c. Co	ounty of Death		
			Calvert						Rising				Cecil		
	Funeral Director		5. Social Security 218-18-	7545	6. Se:	x ] M 2√2 F	r. Age (In yrs. 85	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		, Year)	Count	ace (State or try) yland	Foreign
	and w	}	Usual Residence	10b. County	,		10c. C	ity, Town or Lo	ocation				10	d. Inside City	Limits
	death with the Maryland me 23a or 28a-f ehow rmust be notified at	Director	Pennsylvan		este	er		Landenl						1 ☐ Yes	2 <b>X</b> No
	vith th	Dire	10e. Street and N						10f. Zip Code				n of What Coun		
	e 23e	rai	333 Nor	th Cree	ek K	Oad 12. Was Deced	tent Ever in I	18 12	19350 Was Decedent of F		Specify Yes or No-		ited Sta Race-Americ		
Maryland 21215-0036	72 hours after de naturel', or Item	by Funerai		rried 2 Mar		Armed Ford 1 Tes 3 If Yes, Give Year or Da	ces?		If Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)		Black, White, e		
2-0	72 ho natur lical	ted	(Soe	15. Deceder				16a. Dece	dent's Usual Occup	ation during most of wo	rkina	16b. Kind	of Business/Ind	lustry	
2	d within giene. or then "	Completed	Elementary/Sec		J	College (1-	4or 5+)	life.	DO NOT use retire	d)			^		
12	led w tygier her th		12 17. Father's Name	/First Middle	( ant)			Но	memaker	19 Mother's Na	me (First, Middle,		n Her Ov	n Home	<del>}</del>
anc	ntai h	Be	Frank H		, Last)						Krejci	11121001101	amamo,		
2	should ad Me mark matic	ဥ	19a. Informant's		ship (Ty	rpe, Print)		19b. Maili	ng Address (Street			r, City or T	own, State, Zip	Code)	
Z	od 2 strate		Barbara						North Cre						
ē,	jes 1 and 2 should be liled within of Health and Mental Hygiene. If Item 27 is marked other then "r		20a. Method of Di	isposition			20b.		sition (Name of matory or other pla				ition - City or To	wn, State	
altimore,	Pag ment: ant:			5 Other (	Specify)		itate	A. Ferri	is & Co., I	nc. 2008			st Chest	er, PA	
Ba	permit. Departr Importe any Inj		\		Q	H .: 1	. )	H	Name and Address icks Home 03 W. Sto	e for Fur	erals, P	kton	MD 21	.921	
	Physician /Medical		23a. Part1. Enter shock, or he Immediate Cause disease or condit resulting in death	eart failure. Lis e (Final tion	or complet only o	lications that ca ne cause on ea a.	ch line.	th. Do not en	er the mode of dyin					Approximate Interval Betw Onset and D	reen
	Examiner	iner	Sequentially list of any, leading to cause. Enter Unc Cause (Disease of	conditions, In a diate derlying	Į	b. Due to (c	er as a conse	quence of):	7						-
68760,	e be executed sicien and e burial-transit	cai Examiner	that initiated even resulting in death	າເຮ		c. Due to (d	or as a conse	quence of):							
89	rtificate ng phys as the	Medicai			_	-									
P.O. Box	ne death ce the attendii thed for use	Physician/M	IF FEMALE: 23b. Was deceded in the past 1 1 Yes 2 9 Unknow	2 months?	2		nth 2 ☐ Fet ant at time of	al death 3[	⊒Ectopic pregnanc ☑ Other (specify) _	у		230	d. Date of delive Month	-	ear
	uires that the signed by lid be detact	þ	Part II. Other sign	nificant condit	ions co	ntributing to de	ath but not re	sulting in the u	inderlying cause giv	ven in Part I.	23e. Did to	V	o contribute to the		eath? nknown
Division of Vital Records,	nysician: The law requir nis certificate has been si I director, page 2 should	Completed									24a. Was autop perfo 1  Yes	an sy rmed? 22No	24b. Were auto prior to cor death? 1 \( \sum \text{Yes} \)	psy findings a mpletion of ca	vailable luse of
ita	sian: artifica ctor,	Bec	25. Was case reference examiner?	erred to medica	-					26. Place of De	ath (Check only o	ne)			
Ž	Physic this co	2	1 🗆 Yes 2	No.				ER/Outpatie	nt 3 DOA		Home 5 ☐ Resid			()	
ion	ng F tter men	ation;	27. Manner of De.  1 Natural 2 □ Accident	5 Pendi	ing tigation	28a. Date o (Monti	f Injury h, Day Year)	28b. Time of Injury	Wo	ryat rk? ]Yes 2∐No	28d. Describe h	now injury o	occurred		
Divis	al or Atte s atter des il Directo	Certification;	3 Suicide 4 Homicide	6 🗌 Could deten	I not be mined	288. Place	of Injury - At I		reet, factory, office		28f. Location (S City or Tox	Street and I vn, State)	Number or Rura	l Route Numb	ber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medicai C	29a. Certifier (Check only one)	Certifyi	ing Phy	rsician: To the iner: On the ba and mann	sis of examin	nowledge, dear nation and/or in	th occurred at the ti	me, date and plac opinion, death occ	e, and due to the curred at the time,	cause(s) ar date and p	nd manner as si place, and due to	tated. the cause(s)	
	To the within 2 To the comple	ž	29b. Signature ar	od title of certifi	er _	>	-	v	29c. Licen:	se number 64	49	29d. Date:	signed (Month,	Day, Year)	
			20 Name and ad	dress of person	n who c	ompleted cause	of death (Ite	m 23a) (Type	Print)	e 302	ElKton	Mr	219	21	
	Sta Regista		31. Date filed (Mo	onth, Day, Year	2008		egistrar's Sign	nature	K)					,	

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 6:00AM Mae 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Easton Talbot Hospice If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F 200-22-6388 84 Yrs. 8-11-1923 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 Yes 2 No Talbot Easton  $\mathcal{L}\mathcal{M}\mathcal{D}$ Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 201 Federal Street Apt. #19 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify: White Completed by 3 ☐ Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State of PA Accounting/ Records 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emma Knapp 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4002 Pine Top Ct. Hurlock, MD 21643 Janis Mc Crea 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 2-25-08 Hanover, MD

22. Name and Address of Polity Anatomy Gifts Registry 4 onation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 7522 Connelley Dr. Ste. P Hanover, mo 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (AICINOMA (4/ Physician R171 724 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the HospItal or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician al Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Inknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate har rector, page 2 1∐ Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Anatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation s after death.

I Director; / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours at To the Funeral C 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MO 2.2501

State Registrar

DHMH 17 Rev 1/2001

598 Cynwood Dr. Steloy Easton, MD 2160

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 2 5 2008

Jorge Abrego, MD
31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

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		1 - State Registrar	Ce	rtificate of Death	) R	eg. No.
Physic		Decedent's Name (First, Middle, Last)  HANNAH S. LANE			2. Date of Dea Month	Day Year
/Med Exam		4a. Facility Name (If not institution, give street and	number)	4b. City, Town, or Location	of Death	Y 22 2008 4:00PM 4c. County of Death
		WILLIAM HILL MANOR		EASTON		TALBOT
Funera Director	_	5. Social Security Number  220–05–1008  Usual Residence of Decedent	7. Age (In yrs. last birthday)  85 Yrs.	If Under 1 Year   If Under   Months   Days   Hours	8. Date of Birth Min. (Month, Day)	Year) Country)
yland now at		10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Li
e Mar 8a-f sh otified	ctor	MD TALBOT	EA	STON		1 X Yes 2 □
with the a or 2	D.F.	10e. Street and Number 501 DUTCHMANS LANE		10f. Zip Code		0g. Citizen of What Country?
death ms 23	Funeral Director	11 Marital Status 12. Was D	ecedent Ever in U.S. 13.	Was Decedent of Hispanic O If Yes, specify Cuban, Mexica	figin? (Specify Yes or No-	USA 14. Race - American Indian,
Baltimore, IMaryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any injury.	by	1 Never Married 2 Married 1 7 Yes,	es 2X No	1 ☐ Yes 2 TNo Specify		Black, White, etc.  Specify: WHITE
21215-0036 d within 72 hours af giene. er than "natural", or , the Medical Exa <u>m</u>	Completed	15. Decedent's Education (Specify only highest grade complete	ed) 16a. Dece	dent's Usual Occupation kind of work done during mo DO NOT use retired)	st of working	16b. Kind of Business/Industry
V121	dmo		e (1-40r 5+)	LES CLERK		RETATI.
ind 2 be filed stal Hygi d other event, ti	Be C	17. Father's Name (First, Middle, Last)			ner's Name (First, Middle, I	
Ylal	2	WILLIAM H. SCHUYLER,			NNA M. FAULK	
Maryland of 2 should be file th and Mental H. 27 is marked oth		19a. Informant's Name/Relationship (Type. Print)  ALVIN LANE, SR/HUSBAN		•		r, City or Town, State, Zip Code)  CENTREVILLE, MD 21
or Health of Health fitem 27		20a. Method of Disposition	20b. Place of Dispo			20c. Location - City or Town, State
Baltimore, permit. Pages 1 a Department of Her Important: if item any injury or othe once.		1 ■ Burial 2 □ Cremation 3 □ Removal fro 4 □ Donation 5 □ Other (Specify)	MD VETRA	NS CEMETERY	2/29/2008	HURLOCK, MARYLAND
Balti permit. Departr Imports any inju		21. Signature of Funeral Service Licensee	aced F	2. Name and Address of Facil <b>ELLOWS, HELFE</b>	NBEIN & NEWN	AM FUNERAL HOME PA
#		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	2	UU S. HARRISO!	N ST EASTON.	MD 21601
Physician	80.0	Immediate Cause (Final disease or condition	a each line.	MUDEM	deal One	Interval Between Onset and Deat Occur
/Medical Examiner		resulting in death)	to (or as a ginsequence of):	0	1 1:11	1 X C
Ladimilet		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	to (or as a con = quence of):	and Wheren	rdiche Hea	al Desere lotge
cuted of	Examiner	that initiated events				
sO, e exection and sign and unial-tr			to (or as a consequence of):			
68 / 60, rificate be executed by physician and as the burial-transit	edical	d				
BOX (eath certification attending for use as		23b. Was decedent pregnant	outcome pf pregnancy re birth 2 □ Fetal death 3[	Testania programanav		23d. Date of delivery
e deat he atte	Physician/M	In the past 12 months?		□Ectopic pregnancy □ Other (specify)		Month Day Year
Hecords, P.O. Box The law requires that the death cer tte has been signed by the attendin age 2 should be detached for use	Phy	Part II. Other significant conditions contributing to	o death but not resulting in the u	ınderlying çause given in Part	I. 23e. Did to	bacco use contribute to the cause of death
rdS, quires in signe	d by	Oranitin 2° lo	Cynifold (Sor	vel Liguding	1 🗆 Y	es 2 No 3 Probably 4 Unkr
Hecords, The law requires t te has been signe age 2 should be o	Completed	Danessin 10		0	24a. Was a	
al K		Dementin of Uli	shermers Typ	20	perfor	med? death? 2☑No 1 ☐ Yes 2 ☐ No
Or VITAL P Physician: Th rithis certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital:	☐ Inpatient 2 ☐ ER/Outpatien	Othor	ce of Death (Check only on	
On or	$\parallel$ $\vdash$ $\vdash$	27. Manufir of Death 28a. Da	ate of Injury 28b. Time of Injury Injury			ence 6 Other (Specify) ow injury occurred
VISION Attending r death. ector: After by the fune	catio	2 Accident investigation		M 1 ☐ Yes 2 ☐		
LIVISION OF VITAI I or Attending Physician: T after death. I Director: After this certificat d in by the funeral director, ps	Certification:	determined 286. Pl	ace of injury - At home, farm, stillding, etc. (Specify)	reet, factory, office	28f. Location (Si City or Town	treet and Number or Rural Route Number, n, State)
Hospita 4 hours Funeral ely fille	Medical C	(Check only 2 Medical Examiner: On th	the best of my knowledge, deat e basis of examination and/or in lanner stated.	th occurred at the time, date a nvestigation, in my opinion, de	and place, and due to the c eath occurred at the time, c	ause(s) and manner as stated. late and place, and due to the cause(s)
To the I within 2: To the I complet	Me	29b. Signature and title of certifier	00 0.5	29c. License number		9d. Date signed (Month, Day, Year)
		Ndliam Mas	od / (n)	D08	715	2/23/08
10		30. Name and address of person who completed of WILLIAM H. WOOD, JR. 1		·	ያቸበህ MD 2140	11
St	ate	31. Date filed (Month, Day, Year) 32	2. Pogistrar's Signature		LUM, EID ZIOC	/ 1
Regis		FEB 2 7 2008	been & A	and a		
DHMH 17 Rev 1/	2001					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 21 **Physician** 5:10PM<sup>M</sup> **FEBRUARY** 2008 NAOMI M. LABOMBARD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT MEMORIAL HOSPITAL AT EASTON EASTON if Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) JAN 3,1924 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X F MARYLAND 84 Yrs Director 220-16-9693 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show Department of Health and Mental Hygiens.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at once. 1 XYes 2 □ No Funeral Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21601 USA 700 PORT ST. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 **X**No 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: WHITE Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSE'S AIDE HOSPITAL 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I ant: If item 27 is marked of ANITA DORTHEA EBERHARD CLARENCE W. WOOTERS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELEANOR PLAGGE/SISTER 708 EASTSIDE AVE., ST. MICHAELS, MD 21663 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2/27/2008 EASTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) SPRING HILL CEMETERY 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Tough 21. Strausky 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one caus on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** 120 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Upe to (or as a consequence of): Examiner law requires that the death certificate be executed as the burial-tra Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Yea 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 → Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 400 1□ Yes al or Attending Physician: after death. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 R/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by Hospital 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier, 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar WILLIAM H. ROBINS M.D. 200 CIVIC AVE., SALISBURY, MD 21804

Date filed (Month, Day, Year)

32. Degistrar's Signature

31. Date filed (Month, Day, Year) 32. Begistrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pogistrar's Signature

08-01693	
Harvey Long	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 08082 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day February 22, 2008 Long Harvey 2120 hrs Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Prince Georges Hospital Center Cheverly 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oreign Country) Months Days Hours Director Oct. 3, 1947 D. C. 60 578-60-0150 1X M 2 F Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 X Yes 2 No 23a or 28a-f show notified at once. Prince Georges Capitol Heights within 72 hours after death with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 20743 U. S. A. # 302 6856 Walker Mill Road Funeral 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. White, etc. Armed Forces? 1 X Never Married 2 Married Yes 2 X No 5 Black If Yes, Give Yea Yes 2 No specify: Specify: 4 Divorced Widowed 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Construction permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Injury or other traumatic event, the Medical.] Laborer Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)
Ernest Eugene Long, Sr. Be Willie Mae Rose 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٩ 19a. Informant's Name/Relationship (Type, Print) Lisa Marie Cummings 5939 Fisher Road #102 (Niece) Temple Hills, Md. 20748 20c. Location - City or Town, State 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 03/06/2008 Beltsville, Md. Removal from State Chesapeake Crematory Donation 5 Other Specify 21. Signatu of Funeral/Service Licensee 22. Name and Address of Facility 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart D.C 20010 Approximate Interva **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last e attending physician and for use as the burial - tran Physician/Medical AMENDED 23a, 27 per ME g877 3/26/08 amh X UNPENDED law requires that the death certificate be Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Day Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 5 Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has I death? performed? Yes 2 V No Yes 2X No the Hospital or Attending Physician: hin 24 hours after death. 26.Place of Death (Check only one 25. Was case referred to medical Be examiner? Hospital: 1 ✓ Inpatient 2 Other, Nursing Home 5 Residence 6 Other: DOA ER/Outpatient 3 10 1 🗸 Yes No 28d. Describe how injury occurred 28c. Injury at Work? After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification; within 24 hours after according to the Funeral Director: A' 1 XX Natural Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 Suicide Could not be or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E March 1, 2008 alline 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Margarita Korell MD.

32. Registrar's Signatu

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month, Year **Physician** 150 AM LYLES OHN 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARGIANA SKCTIMORE OF BALTIMORE CITY UNIVERITY MEDICAL DENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours 1 M 2 □ F MARYLAND 577-04-4421 40 22, 1968 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1. Yes 2 □ No Director MD CHARLES WHITE PLAINS 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 9922 RHODES WAY 20695 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Never Married 2☐ Married ☐Yes 2 XNo Yes, Give 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: BLACK 3 Widowed 4 Divorced Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", any Injury or other traumatic event, the Medical Exa. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 LABORER STATE GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEROY LYLES MARY LUCILLE COOPER LYLES ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY L. LYLES/MOTHER 9922 RHODES WAY, WHITE PLAINS, MARYLAND 20695 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ST. CATHERINE CH. CEMETERY 02/29/2008 MCCONCHIE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee LYDIA C. THORNTON JOHNSON MC583 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 Approximately and address of Facility THORNION FINERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 Approximately and address of Facility THORNION FINERAL HOME, P.A. Approximately and address of Facility THORNION FINERAL HOME, P.A. Approximately and address of Facility THORNION FINERAL HOME, P.A. Approximately and address of Facility THORNION FINERAL HOME, P.A. Approximately and address of Facility THORNION FINERAL HOME, P.A. Approximately and address of Facility THORNION FINERAL HOME, P.A. Approximately and address of Facility THORNION FINERAL HOME, P.A. Approximately and address of Facility THORNION FINERAL HOME, P.A. Approximately and address of Facility THORNION FINERAL HOME, P.A. Approximately and address of Facility Approximately and address of Facility THORNION FINERAL HOME, P.A. Approximately and address of Facility Approximately and address of Facility THORNION FINERAL HOME, P.A. Approximately and address of Facility Approximatel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEPATORENAL SINDROME Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CIRRITOSIS ACCONTOLIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Day Year 5 Other (specify) signed by the at the detached for ☐Yes 2 ☐ No 9 □Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SEPSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an POSTERIOR NASAL has autopsy performed? 1□ Yes No 2□ No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Nonpatient 2 ER/Outpatient 3 DOA ၉ within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral. 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) Injury 1VZ Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide \* Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifier

SHVA

31. Date filed (Month, Day, Year)

FEB 2 8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOSKOVIT

2008

MI

32. Redistrar's Signature

DHMH 17 Rev 1/2001

29c. License number

1225246077

GREENE

ST

29d. Date signed (Month, Day, Year)

MM 21201

BALTIMORE

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician**  $P^M$ Dorothy M. Morris February 26, 2008 4:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday **Funeral** Days 1 M 2 T 016-20-0192 81 Director 18,1926 New York Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show diral Examiner must be notified at 1 ☐ Yes 2 🛣 No Directo MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1616 Farnborn St. 21114 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. tem 27 is marked other than "natural", or ite wher traumatic event, the Medical Examiner 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John N. McDowell Dorothy W. Broas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John M. Morris/Son 10345 Sixpence Cir. Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department o Injury or 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat'l Cem. 3/20/2008 Arlington, VA 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licens 6512 NW Crain Hwy. Bowie, MD 20715 23a. Parl 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Approximate Interval Between Onset and Death or on plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) car **Physician** 5vda /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of physician and the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 | Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the funn

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB 2 9 2008

32. Registrar's Signature

2225E

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0029571

Defense thmy, Crofton, MD 21114

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 27, Day 2008 Mee **Physician** Joy 6:30 P Karen /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Chever1v Prince George's General Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 1, 1939 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Nebraska 1 M 2 F 68 508-46-8369 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 28a-f show notified at 1 ☐ Yes 2XXNo Forestville Director Maryland Prince George's death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Examiner must be now or other traumatic event, the Medical Examiner must be nown. 20747 7908 Daniel Drive USA 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White, etc. 1 ☐ Yes 200 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2XXNo Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 Vear Federal Government Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Claude Hennig Dorothy Prussia ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7908 Daniel Drive Forestville, Maryland Wendy Joy Mee - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State March 3, 2008 Suitland, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signature of Funeral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland pl. /lef 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause, in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Exami that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending ph 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an perforn death? 1 ∐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 3 DOA 1 🗌 Inpatient 2 ER/Outpatient Certification: To 1 🗌 Yes 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) State 9 2008 FEB 2 Registrar

30. Name and add as of pe



on who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	State o	f Marylan		artment of F tificate of	lealth and N <i>Death</i>		jiene <sub>leg. No.</sub> 2	008	08086
П	Divi.:		Decedent's Name (First, Middle,	Last)					2. Date of Dea Month	th Day	Year	3. Time of Death
В	Physici /Medic		Martin Jose						2/2	26/200	88	6:09 P M
)	Examin	er	4a. Facility Name (If not institution,					r Location of Death			nty of Death	
Š			Washington Adver	ntist Hos	7. Age (In yrs.	last birthday)	Takoma If Under 1 Year		8. Date of Birth		gomery 9. Birthr	place (State or Foreign
	Funeral Director		180-03-9763	1 <b>X</b> M 2□ F		6 Yrs.	Months Days	Hours Min.	3/26/19	, Year) 911	Penns	oylvania
	P _		Usual Residence of Decedent		10a Cit	y, Town or Lo	ection					I0d. Inside City Limits
	shov shov	'n	10a. State 10b. County									1⊠Yes 2 No
	the M 28a-f notifie	Director	MD Prince  10e. Street and Number	George's	ы ∣ Нуа	ttsvil	10f. Zip Code		1	10g. Citizen	of What Cou	ntry?
	3a or		4223 Nicholson	St.				20781		U.S	. A .	
	death	Funeral	11. Marital Status		edent Ever in U.	.S. 13. \	Was Decedent of H	dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Dican, etc.)		Race - Americ	
36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by Fu	1 ☑ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 🔀 Yes	2 □ No		1 □ Yes 2 🖫 No				ecify:	
ö	hours fural'	ed b	15. Decedent's		ates: WWI]	16a. Deced	dent's Usual Occup	oation		16b. Kind o	Wh:	
15	in 72 In "na Medic	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (	1-4or 5+)	(Give life, L	kind of work done DO NOT use retire	during most of world)	king			
212	ed with	Completed		4			Librar	т -				eme Court
Maryland 21215-0036	be file	Be	17. Father's Name (First, Middle, L	ast)				18. Mother's Nam		Maiden Sun	name)	
3	hould d Mer marke matic	욘	Josef Manning  19a. Informant's Name/Relationshi	in (Type Print)		19b Mailir	ng Address (Street	Katherin		er. City or To	wn. State. Zii	Code)
Ma	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene. If marked other than "natural", or items 23a or 28a-f show litem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at		J. Fred Manning				•	rings Rd.			•	-
re,	is 1 and 2 of Health a Item 27 Is other trai		20a. Method of Disposition		20b. F		sition (Name of matory or other pla		Date		on - City or T	
imo	Page nent c		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other ( <i>Sp</i>		State		art Cath		/4/2008	Bath,	PA	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other		21. Signature of Funeral Service/L	icensee	l,		2. Name and Addre	•				imore Avenue
	<u>~</u> ~ ~ ~ ~ ~		H Consta	nee /c	lasel			neral Hon			tsvil	Le, MD 20781 Approximate
	Discontinuo		23a. Part1. Enter the disease, or on shock, or heart failure. List of limmediate Cause (Final	nly one cause on e	each line.	Car	200	- Deal	<i>L</i> / <sub>4</sub>			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Du to	(or as a conseq	uence of):	IC OCCU	c Dea				
	Examiner		Sequentially list conditions	b. 13h	enne	ca	redur	mant	1			
	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a conseq	uence of):	and L	C	Q			
	xecute and II-tran	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):	(OUVI 1º	force	<u> </u>			
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical E		C <sup>d</sup>								
9	tificat ng phy as the	<b>ledi</b>	15 CE1111 5									
Вох	leath certific attending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live	itcome pf pregn birth 2 ☐ Feta	al death 3	⊒Ectopic pregnand	су		23d.	Date of delive	ery Day Year
0.	ne dea the at hed fo	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg 9□Unkn	nant at time of one of the original	death 5	Other (specify) _					
Δ.	requires that the d een signed by the hould be detached	'Ph	Part II. Other significant conditio	ns contributing to c	death but not res	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	obacco use	contribute to	the cause of death?
rds	w requires that s been signed I should be det	d by							101	∕es 2□N	lo 3□Pro	bably 4 [Munknown
000	> 20 20	olete							24a. Was	an 2	4b. Were aut	opsy findings available ompletion of cause of
R	The ate h page	Completed							perfo 1∐ Yes	rmed? 2LXNo	death? 1 ☐ Yes	2 No
/ita	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	Hamital			10:		th (Check only o	ne)		
or Vital Records,	ys dir	은	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐		R/Outpatie	II SLIDOA		lome 5 Resid			ify)
on	ding After fune	tion	1 Natural 5 Pending 2 Accident investig	(Mor	nth, Day Year)	Injury	Wo	ork? ]Yes 2∐No		,.,.,.		
Division	or Attend after death. Director: / in by the f	ifica	3 Suicide 6 Could n 4 Homicide determi	200. Flace	e of injury - At h	ome, farm, sti	reet, factory, office		28f. Location (S City or Tox		umber or Ru	ral Route Number,
Ö	pital or Attendous after deathous after deatheral Director:	Certification:										
/	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Certifying (Check only 2 Medical I	Examiner: On the I	e best of my kno basis of examina nner stated.	owledge, deat ation and/or ir	th occurred at the to nvestigation, in my	time, date and place opinion, death occi	e, and due to the urred at the time,	date and pla	d manner as ace, and due	stated. to the cause(s)
	To the Hos within 24 ho To the Fun completely	Mec	- '/				29c. Licer	se number		29d. Date si	igned (Month	, Day, Year)
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	5		30. Name and address of persons 31. Date filed (Month, Day, Year) FEB 2.3.	who completed cau	use of death (Ite	m 23a) (Type,	Print)	DN 85	HVALL	2//1/		2000
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DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760

State

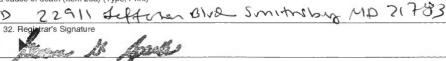
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10 (m

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

an mo



DHMH 17 Rev 1/2001

Registrar

DOOS7600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 15 Year 2008 Physician Month Noramn F. Mann prhanh /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bultimore-washington medical Center Hrunde ar If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year)
Jan. 15, 1 9. Birthplace ( Country) Canada 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2 ☐ F 226-54-4871 1939 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2X No Director MD Anne Arundel **Gambrills** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21054 Canada 2604 Chapel Lake Dr. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. t ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Credit Union President permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Morton Major Norman Mann, Ret. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2604 Chapel Lake Dr. Gambrills, MD 21054 19a. Informant's Name/Relationship (Type. Print) Charlene Mann/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/1/2008 Metropolitan Crem. Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Beall Funeral Home Bowie, MD 20715 6512 NW Crain Hwy. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a of sequence of): Physician/Medical Examiner burial-tran Due to (or as a consequence of): the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f a∏ I Inknown 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by m 0~ 1 Tyes 2 V No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an was and autopsy performed ves 2 1∐ Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Mapner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, Physician:

requires that the death certificate be executed

physician

this

After

death.

death with the Maryland

hours after

filed within 72

other

Maryland 21215-0036

Baltimore,

Hospital or Attending hin 24 hours after death the Funeral Director: completely 2

Registrar

Medical

29a. Certifier

29b. Signature

(Check only one)

31. Date filed (Month Pay FFR 2 9 2008 FEB 2 9

and title of cer

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

8006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:01 AM February 23, 2008 Η. MacGowens James /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Months Hours Min 1 □ M 2 □ F 1933 412-38-4486 74 Sep. 03 Alabama Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 X Yes 2 ☐ No Director DC Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20017 4726 6th Place, NE USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: **Black** þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) Furman Builders, Inc. permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other trainmant. Construction Superintendent yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Carter James MacGownes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4726 6th Place, NE Washington, DC 20017 Donna J. MacGowens/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 02-28-2008 | Alexandria, VA 21. Signature of Funeral Service License 22. Name and Address of Facility Marshall's Funeral Home, Inc. Washington, DC 20011 4217 9th Street, NW 23a. Pary Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE CARDIO PUL MOMBAY Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine be executed that initiated events resulting in death) Last burial-tran and Due to r as a consequence of) Box 68760. attending physician Physician/Medical as the l IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Dav Year Гoг 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 10 Yes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes ပ 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

P.0. Division or Vital Records.

To the Hospital or Attending Physil within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director.

State Registrar

Medical

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

🕻 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

February 23,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

34151+AMILTON ST HYATTSVIILE, MD 20792 Tel MD

29a. Certifier

#### 08-01270

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hydiene

Beatrice Atiyo O		1- For State	tate of M	aryland /		rtment of		nd Mei	ntal Hy		Reg. No.	2.0	n a	0809
Physicia		Registrar  1. Decedent's Name (First, Mic	dle,Last)							2. Date of De	eath	- Kana	3.	. Time of Death
Medical Exami		Beatrice Ap	ivo Om	noro						Month February				0041 hrs
Fr. S.		4a. Facility Name (if not institu	ion, give street	and number)			4b. City, Town,	or Location	of Death		- 1	. County of De		
4		Shady Grove Hospit					Rockville			1		Montgomer	•	I (Ot-t
Funeral		5. Social Security Number ukn	6. Sex	7. Age	(In yrs. la	ast birthday)	If Under 1 Y Months D	ear If Uni	der 24Hrs.			/DD/YYYY) 9. Fo	reian	
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215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once		17. Father's Name (First, Midd	·							(First, Middle		Surname)		
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Balt permit. Departi Import injury		*// // /	Thomps	212-		7/	00 Geor	coia	McG	uire F	uner	al Ser	vic	e, Inc. DC 20012
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Division pital or Attendio ours after death. teral Director:  filled in by the fu	Certification:	de	ould not be	Specify) Loc			set, factory, only	oe bananiy,	, 0.0.	or Tow	n. State)			Gaithersburg, MD
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To the To the comple	Mec	29b. Signature and title of cer		nanner stated.		<u> </u>	29c. Lic	ense numb	er		29d	. Date signed	(Mont	th, Day, Year)
4		( a y of	HA	0 O a	1-		0.	C.M.E.			Fe	bruary 14,	2008	3
		30. Name and address of pers	on who comple	ted cause of d	eath (Iten	n 23a)							-	
			ssistant Me	edical Exan	niner	111 Penn	Street, Balt	imore, N	/ID 2120	)1				
	tate	FFD (c)	3° 2008	37 Registra	r's Signat	ure	(E)							
Reais	Heli	~ ~ (		Property of		1								

SH-L

31. Date filed (Month, Day, Year) State MAR 04 Registrar 2008

R. GUEDENET, M.D.,

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

032518

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#1perMD, 3/5/08, EMW, MbCo Certificate of Death Reg. No. 🦾 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ercelle Auriti Robinson Day Year **Physician**  $A^{M}$ Ereclle Joy February 21 2008 9:40 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner College Park Prince Georges 3520 Metzerott Road If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthdav 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 1 1 F 578-20-5520 Director 28, 1922 Washington, D.C. 85 June Usual Residence of Decedent filed within 72 hours after death with the Maryland a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 K Yes 2 □ No Director MD Prince Georges College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a c must be U.S. by Funeral 3520 Metzerott Road 20740 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or item Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify: African 1 ☐ Yes 2 X No 3 Widowed 4 Divorced American Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be s 1 and 2 should be fir t Health and Mental H Item 27 is marked oth other traumatic ever ပ Anna Wilson Linus Joy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian C. Robinson / Son 12719 Two Farm Drive, Silver Spring, MD 20904 other or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 jo 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven 2/28/08 Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. Shoe andew 7400 Georgia Ave., N.W. Washington, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition Abdominal Aortic Aneurysm-Rupture /Medical Due to (or as a consequence of): Examiner Atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-tran Due to (or as a consequence of) physician Physician/Medical the as IF FEMALE ase 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🕱 No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performed? 1☐ Yes 2☑ No certificate Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury Hospital or Attending 1 XNatural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident after death Director: the 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifler (Check only one) соттретельно within 2 To the F and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ျ D50913 EU. February 26, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) FEB 28 2008



Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

Greenbelt, MD 20770

		1 - State Registrar  1. Decedent's Name (First, Middle, Last)	partment of Health and Certificate of Death	2. Date of Deat	<sub>eg. No.</sub> 2008 h	3. Time of Death
Physici /Medi		WALTER A KHULE		Month O2	2 voo	
Exami	ner	4a. Facility Name (If not institution, give street and number) 2607 Chapel Lakr Dr.	4b. City, Town, or Location of Deat Gambrills	th	4c. County of Dea	
Funeral Director		5. Social Security Number 540-07-7361 6. Sex 2□ F 7. Age (In yrs. last birtho 91 Yrs.	Months Days Hours Min		9. Bir 916	thplace (State or Foreign ountry) OR
yland now at		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town o				10d. Inside City Limits
he Mar 28a-f sl otified	ector		rills		Og. Citizen of What C	1 ☐ Yes 2125No
3a or 3	a Dir	10e. Street and Number 2607 Chapel Lake Dr.	10f. Zip Code 21054	'	USA	ountry :
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hijury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director		I3. Uas Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	
n 72 hor "naturi	Completed	(Specify only highest grade completed) (C	ecedent's Usual Occupation Rive kind of work done during most of wo fe. DO NOT use retired)	orking	16b. Kind of Business	s/Industry
CIC d withii giene. er than , the M	Somp	Elementary/Secondary (0-12)   College (1-4or 5+)	inance		US Gov	't
uld be file Mental Hy nrked oth	To Be (	17. Father's Name (First, Middle, Last) William Walter Rhule	l l	me (First, Middle, I	Maiden Surname)	
d 2 sho th and 7 is ma trauma			lailing Address (Street and Number or R 07 Chapel Lake Dr.		; City or Town, State,	
Pages 1 and nent of Health int: If item 27 ury or other tr		20a. Method of Disposition  20b. Place of D  cemetery,	isposition (Name of crematory or other place)	Date	20c. Location - City or	r Town, State
permit. Pa Departmer Important: any injury		4 □ Donation 5 □ Other (Specify) Mary Lan  21. Signature of Funeral Service Licensee	d Veteran Cem 2/27		crownsvill uneral Hom	
		23a. Part1. Enter the disease, or conflications that caused the death. Do not	12 Ridgely Ave. A			Approximate
Physician /Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of)	Ca			Interval Between Onset and Death
Examiner	je.	Sequentially list conditions, if any, leading to immediate b	:			
be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of)  c				
ate be ex nysician a		d.				
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of de Month	elivery Day Year
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w requires to the control of the con	Completed			1 X Y	n 24b. Were a	Probably 4 Unknown autopsy findings available
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V ILC. sician; certific rector,	Be	25. Was case referred to medical examiner?  1  Yes	Other:	eath (Check only on	·	
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r Attending er death. irector: Aftel	Certification:	2 Accident sinvestigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Si City or Town	treet and Number or F n, State)	Rural Route Number,
e Hospital c 24 hours af e Funeral D letely filled ii	Medical Cer	29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, one)  2 Medical Examiner: On the basis of examination and/and manner stated.				
Somple the state of the state o	Me Y	29b. Signature and title of centifier and tit	29c. License number $\mathcal{V}_{143}$	3	9d. Date signed (Mor	orth, Day, Year) ang 25, 2008
1,200	<b>Y</b>	30. Name and address of person who completed cause of death (Item 23a) (Ty  MICHAEL  Lavery  Lavery  M. CHAEL  Lavery  M. CHAEL  M. CHAE	PP, Print) DEFEN	SE HIG	HWAY AM	ung 25, 2008 Vor Apolis in 12
St Regist	ate rar	31. Date filed (Month, Day, Year)  September 1997	South .			
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			RIGINAL			

DHMH 17 Rev 1/2001

			1 - For State Registrar			nd / Dep		f Health	and M	lental Hyg	iene	3 080	94
1	Physici /Medi	cal	Decedent's Name (First, Middle,     DE     Aa. Facility Name (If not institution,	44		BING		n, or Location	of Death	2. Date of Dea Month	th	-	I
* *	Funeral	ier	Anne Arundel Med	ical Cent	er	. last birthday,	If Under 1 Ye Months Da	Annap	olis	8. Date of Birth (Month, Day 12/4/I	Anne	Arundel  Birthplace (State or Country)	<sup>r</sup> Foreign
8	Director  • ehow  • parallel at the parallel a	or	Usual Residence of Decedent  10a. State 10b. County  MD Anne Ar	unde1		ity, Town or Lo				12/4/1	932	NY  10d. Inside City 1 ☐ Yes	
	72 hours after death with the Maryland naturel', or iteme 23a or 28e-1 ehow Jigal Exacid writinal be redified at	rai Director	10e. Street and Number 456 Laurel Valle				10f. Zip Cod	2			Og. Citizen of Wha	SA	
9036	rours after de urei', or item	d by Funeral	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	es? No		1 ☐ Yes XX	No Specify	<i>'</i> :	city Yes or No- Rican, etc.)		American Indian, White, etc. White	
Maryland 21215-0036	ed within 72 h giene. er then "natu	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	Education grade completed) College (1-4	4or 5+)		dent's Usual Oc kind of work do DO NOT use re ior Vic				16b. Kind of Busin	ess/Industry	L Bank
ıryland	should be file nd Mental Hy marked oth imatic event	0	17. Father's Name (First, Middle, La Ralph Matthews  19a. Informant's Name/Relationship			19b. Maili	ng Address (Str	Mat	tilda	Nahama	Maiden Sumame) r, City or Town, Sta	ite Zin Code)	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or iteme 23a or 28e-1 ehow with julyry or other traumatic event, the Medical Exacting must be notified at ance.		Devra Williams  20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3	Daughte:	20b. I	456 L	aurel Va	alley (	Ct.	Arnold	MD 2101	y or Town, State	
Baltimore,	permit. Pa Departmen Importent eny injury		4 Donation 5 Other (Spe 21. Signature of Funeral Service Line		30	2:		dress of Facil	ity Har	desty F	Annapolis uneral Ho , MD 2140	me, P.A.	
760,	Physician and /Medical Examiner and physician and physician and the print th	dicai Examiner	23a. Part1. Enter the disease, or or shock, or heart failure. List or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	r as a consec	quence of):	m on	tying, such as	s cardiac o	r respiratory arr	est, Luxe	Approximate Interval Betwoen Constitution Co	reen
P.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No. 9 ☐ Unknown		h 2∏Feta nt at time of c	al death 3	Ectopic pregna Other (specify,				23d. Date of Month		ear
	requir	þ	Part II. Other significant condition:	s contributing to dea	th but not res	sulting in the u	nderlying cause	given in Part	I.		9s 2□No 3[	Probably 4 U	nknown
Vital Records,		Be Completed	25. Was case referred to medical examiner?		,,,,	<i>)</i>		26. Plac	e of Death	autops	med? deat	e autopsy findings a to completion of ca h? Yes 2□ No	use of
Division of \	ding Phys h. After this funeral di	Certification: To	27. Manger of Death  1 Chatural 2 Accident investigat 3 Suicide 6 Could not	28a. D te of (Month,		28b. Time of Injury	28c. Ir	Other: 4 No njury at Vork? Yes 2	2		ence 6 Other (	Specify)	
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)	To the Hospita within 24 hours To the Funeral completely filled	Medical	29b Signature and title of one tiffier	and manne	r stated.	ition and/or in	29c. Lig	y opinion, dea	ath occurre	ed at the time, d	ate and place, and 9d. Date signed (M	fonth, Day, Year)	2008
	NO	h	30 Name and address of person what is a second of the seco	o completed cause	death (Item	n 23a) (Type.	Print) D	EYENS	SE A	76HWA	y ANNA	Poly MD.	1144
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3,	Physicia		1. Decedent's Name (First, I	Aiddle, Las	t)								2. Date of De Month	ath Da	ay Year	3. Time of Death
	/Medic		Lucy Victo										Februa	-	21, 2008	23:10 PM
	Examin		4a. Facility Name (If not insti								Location of	of Death		40	c. County of Death	1
<b>€</b>	Funeral		Laurelwood Nu 5. Social Security Number	rsing 6. Se				ation ation	II Under	1kto 1Year	If Under		8. Date of Bir	th	Cecil 9. Birth	nplace (State or Foreign
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	pu »		Usual Residence of Decede 10a. State 10b. Co			10	Oc City	Town or Lo	antion							10d. Inside City Limits
	shov shov	ō		cil		"	E1k		Cation							YYes 2 □ No
	the A	rect	10e. Street and Number	.011					10f. Zip	Code				10g. C	itizen of What Co	untry?
	72 hours after death with the Maryland natural', or Iteme 23e or 28e-f show dical Examiner must be notified at	Funeral Director	1 Laure1 Dri	ve							1921			Un:	ited Sta	tes
	deat	ner	11. Marital Status		12. Was De Armed F	cedent Eve	er in U.S.	13. V	Vas Deced	lent of Hi	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	)-	14. Race - Amer Black, White	
98	or It	by Fu	1 Never Married 2		1 Tes	2 No live No Dates:			☐ Yes 2		Specify:	,	,		Specify: Wh:	
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Baltimore, Maryland 21215-0036	al H al H ot	To Be	17. Father's Name (First, Mi John L. Tes										e (First, Middle B. Dick		n Surname)	
lary	2 sho and h is ma		19a. Informant's Name/Rela				14	19b. Mailin	g Address Box 7	(Street a	704 I	er or Rura	A Route Numb	er, City	or Town, State, Z oad	(ip Code)
e,	1 and Health em 27 ther t		Lorreen Harri 20a. Method of Disposition	LS / I	Jaught	-					- 1		Date		_ocation - City or	
Jo.	ages int of t: If It		1 ☑Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth			State		ce of Dispos netery, crem			1 -	Febru	-			
Ħ	nit. P artme ortan Injur.		21. Signatur of February Se			1	Nort.	h Eas			ST 2	y Cro	2008	nor	al Home	Maryland
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RT	Examiner	liner	Due to (or as a consequence of):  Start Democratic Democratic Democratic Due to (or as a consequence of):  Bue to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):													
,092	te be ysicia	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	l	c. Due to	o (or as a co	onseque	nce ol):								
Division of Vital Records, P.O. Box 68	death certific e attending p od for use as	Physician/Medica	IF FEMALE: 23b. Was decedent pregnal in the past 13 months? 12 9s 2 No 9 Unknown	b. Was decedent pregnant in the past 12 months?  1									ivery Day Year			
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rds	en sig		CAD										10	Yes :	2 □ No 3 □ Pr	obably 4 Unknown
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isic	death ctor: y the	ficat	3 ☐ Suicide 6 ☐ C	ould not ce	28 J. Plac	ce of Injury	- At hom	ie, farm, str			.03 2		28f. Location	Street a	and Number or Ru	ural Route Number,
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	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier 1 29a. (Check only one)	tifying Phi digal Exam	iner: On the	ne best of n basis of ex	caminatio	edge, death on and/or inv	occurred restigation,	at the tim , in my or	ne, date ar pinion, dea	nd place, ith occur	and due to the ed at the time.	cause(	s) and manner as nd place, and due	stated. to the cause(s)
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1			30. Name and address of the	rson who	completed ca	use of deat	th (Item 2	23a) (Type,	Print)				,	^-	1877	
	6		31. Date filed (Month, Day,		M)	CH Paris	1 00	WACH.	im)	C	72	M	LHITLE	ノビ	17726	٠
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			For State Registrar	State of Maryland		artmen rtificate			nd Me	, ,	iene g. No 2	008	080	96
1	Physici		Decedent's Name (First, Middle, Last)  DORTHINE	A. SPEIGHT					2.	Date of Death		Year	3. Time of De 6:08	
	/Medi Examir		4a. Facility Name (If not institution, give st	reet and number)		, ,		Location of			4c. Cc	ounty of Death	DV	
	Funeral		HOLY CROSS HOSPIT.  5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under	1 Year_	PRING	4 Hrs. 8.	Date of Birth (Month, Day,			lace (State or F	oreign
E	Director		578-54-1146	M 2 X F 69	Yrs.	Months	Days	Hours	Min.	8-31-3	8	NC	ury)	
	nyland how lat		10a. State 10b. County	10c. City	, Town or Lo	cation			_			1	0d. Inside City I	
	the Ma 28a-f s otified	Director	MD PRINCE GEO	ORGE ADI	ELPHI	10f. Zip	Codo			10	ng Citize	n of What Cour	1xXYes 2	
	3a or 3	al Dir	1801 METZEROTT ROA	AD.			0783					5.A.	itry .	
	tems 2	Funeral	Tr. Marita Gatas	Was Decedent Ever in U.s Armed Forces?	S. 13.	Was Deced If Yes, spec	lent of Hi	spanic Origi n, Mexican,	in? (Specif Puerto Ric	y Yes or No- can, etc.)	14	. Race - Americ Black, White,		
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🙀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		1 ☐ Yes 2	2 <b>∏</b> No	Specify:			S	pecify: BLA	CK	
21215-0036	72 hou 'natura dical E	Completed	15. Decedent's Educ (Specify only highest grade	ation   completed)	16a. Dece	dent's Usua kind of wor	al Occupa rk done o	ation Juring most (	of working	1	16b. Kind	of Business/In		
121	iene. than "	ldmo	Elementary/Secondary (0-12) 12TH GRADE	College (1-4or 5+)	DIET]		se retired <sub>i</sub>	)			ST.	ELIZABE	TH HOSP	'ITA
nd 2	iges 1 and 2 should be filed within 72 hours after death with the Marylan to Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)	TDEC		-			,	First, Middle, N		ırname)		
Maryland	should and Men is marke	은	CHRISTOPHER C. SN  19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailir	ng Address	(Street a					own, State, Zip	Code)	_
	and 2: ealth ai n 27 is er trau		CALVIN D. COLEMAN-		1			EK DR				ID 2070.		
Baltimore,	Pages 1 and nent of Health Int: If item 27 Iry or other ti		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Re	moval from State	lace of Dispo emetery, crei	matory or o	ther plac		Dat 3-1-0			LAND,M		
altin	- F 49 =		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License									ER F. H		
ä	permi Depai Impoi any Ir		Theodore (	Juckne	7	~						20002-		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cations that caused the deatter cause on each line.  CARDIO-PULMON  Due to (or as a consequ	IANY AI		e of dyin	g, such as c	ardiac or r	espiratory arre	est,		Approximate Interval Betwe Onset and Dea	en ath
*		niner	Sequentially list conditions, any learns to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	uence of):								-	
3760,	ate be executed hysician and he burial-transit	ical Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):									
.O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 XXNo 9 □ Unknown	oc. If yes, outcome pf pregna 1 □Live birth 2 □ Feta 4 □ Pregnant at time of do 9 □ Unknown	Ideath 3	∃Ectopic pr ∃ Other (sp					23	d. Date of deliv Month	ery Day Yea	ar
ds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions con- CHRONIC RESPRATOR	tributing to death but not resu Y FAILURE	ılting in the u	nderlying c	ause give	en in Part I.		23e. Did tob	37		he cause of dea bably 4	
or Vital Records,	e law rec has beer je 2 shou	Completed	END STAGE RENAL D	ISEASE						24a. Was a	V	prior to co	opsy findings av	ailable ise of
alB			25. Was associated to medical					OC Disease	of Dooth /		2 X No	death? 1 ☐ Yes	2 <b>X</b> No	
r Vit	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 🎇 Inpatient 2 🔲	ER/Outpatier	nt 3∐ DC	Othe	ar.		Check only on 5 ☐ Reside		☐Other (Speci	fy)	
0 0	ding Physia. h. After this of		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		8c. Injun Work			d. Describe ho	ow injury	occurred		
Division	Atten	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At ho building, etc. (Specify	ome, farm, sti /)	M reet, factory		Yes 2 □ N		f. Location (St City or Town	treet and n, State)	Number or Rui	al Route Numbe	∋ <i>r</i> ,
	Hospital or 24 hours afte Funeral Dir stely filled in	edical (		ician: To the best of my kno er: On the basis of examina and manner stated.										
	To the within ;	Med	29b. Signature and title of certifier	A1/	)	290		e number		2		signed (Month	Day, Year)	
İ	10		1 pr	- 17 N			טטע	63343			2-1	24 <b>-</b> 08		
_	Ψ		30. Name and address of person who cou IRINA RUBAN, M. I	1500	FORES	T GLE	N RD	. SI	LVER	SPRING	, MD	20910-	1484	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	tur	,								

DHMH 17 Rev 1/2001

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Physicia	F	Registrar Amen 1. Decedent's Name (F	ped #1 pe	er ME, gc 2/29	/08	inouto oi 2				e of Death			3. Time of Death
Medical Examir										oruary 23,	2008	Year	2235 hrs
(		Tony Eugen 4a. Facility Name (if n		e street and number)				Location of Dea	ath			nty of Death e George	
		Prince George					Cheverly	If Under 24	dre 8 Da	ate of Birth/			thplace (State or
Funeral Director		5. Social Security Nun			e (In yrs. Ia		Months Days		din.	ate of Birdi(	VIIVI/DD/ 1	Foreig	'nWash.
Director		579-17-373	24	M 2 F 18	3	Yrs.			9/	/26/19	89		Ď.C.
any	ŀ	Usual Residence of D 10a. State 10	b. County		10c. City,	Town or Location							10d. Inside City Limits
<b>≱</b>	_	D.C. L			Wach	ington							1 X Yes 2 No
larylar 28a-f	Director	10e. Street and Numb	er		WILLIAM	1	0f, Zip Code			10g.	Citizen o	f What Cou	ntry?
ith the Maryland 23a or 28a-f show notified at once.	盲	320 16th S	Street_	S.E			20003					Stat	
h with	eral	11. Marital Status  1 X Never Married	2 Married	12. Was Decedent Armed Forces?		S. 13. Was I If Yes	Decedent of His , specify Cubar	spanic Origin? ( n, Mexican, Pue	( Specify Yerto Rican,	es or No-		Race - Amer White, etc.	ican Indian, Black,
or ite	Funeral			1 Yes 2	X No	1 V	es 2 x No	soecify:			Spec	cifyBlac	le l
ural",	<u>a</u>	3 Widowed		or Dates: only highest grade con	npleted)	16a. Decedent's	Usual Occupa	tion (Give kind	of work do	one 1		of Business/	
72 hou	eted	Elementary/Second		College (1-4 or		during mos	t of working life	. DO NOT use	retired)				
5-0036 led within 7 Hygiene. other than	Comple	12				Courtes	y Cler	k 18.Mother's Na	( <del>-1</del> )	Atialaha Ma		il Fo	od
5-0 iled w Hygie fothe		17. Father's Name (F									igen Sum	iarrie)	
2121 ould be fil Mental I marked	Be	Tony Euger	ne Shaw	Type, Print )		19b. Mailing A	Address (Stree	Lisa H et and Number	or Rural F	Route Numb	er, City or	Town, State	e, Zip Code)
MD 2 id 2 shou lith and N m 27 is n aumatic	٩	Lisa Hill				320 16t			lashi	ngton.	D. C		
		20a. Method of Dispo	osition			Place of Dispositi	on (Name of ce	metery,	Date		20c. Loca	ition - City o	r Town, State
mor ages ent of nt: If			Other Specif	Removal from St	ale	t Lincol		erv 3	/1/20	108	Bren	twood	Md
Baltimore, permit. Pages I at Department of Hee Important: If ite	1	21. Signature of Fund	eral Service Lice	ensee									P.A.
		Alm.	M. Sar	MUI	081	553	8 Mar11	oro Pi	ke Fo	restv	ille	Md, or heart	20747 Approximate Interval
Physician / Medical		failure. List only	one cause on e	each line.		, Do not enter ale	11.000 01 0,9			,			Between Onset and Death
aminer		Immediate Cause (Fi		Due to (or as a cons		of):							
		Sequentially list cond		o									
	ner	if any, leading to imm cause. Enter Underl	nediate Iving Cause	Due to (or as a cons	equence o	of);							
	Examiner	(Disease or injury that events resulting in de	at initiated	Due to (or as a cons	sequence o	of):			_				
recuted	al E			d									1
be exe	dic	UNPENDED		AMENDED							1224 D	ate of delive	en/
cords, P.O. Box 68760, law requires that the death certificate be exhaps been signed by the attending physician should be detached for use as the burial.	Physician/Medic	IF FEMALE: 23b. Was decedent p		23c. If yes, outco	ome of preg	-	il death 3	Ectopic pre	egnancy			nth	Day Year
× 68 th cert tendir	icia	past 12 months?	-	4 Pregnant a	t time of de		er (Specify)						
Box ne death c r the atten	hys	1 Yes 2 N		s contributing to dea	th but not i	resulting in the un	derlying cause	given in Part I.	. 1	23e. Did tob	acco use	contribute t	o the cause of death?
P.O.	by F	Part II. Other signili	cant conditions	s contributing to dea	illi bat not i	resulting in the er		3		1 Yes	2 🗸 N	o 3 Pr	obably 4 Unknown
ds, I quires en sig uld be	ted								_	24a. Was a		24b. Were a	autopsy findings available completion of cause of
COrc law re has be	Completed								-	autops perform 1 ✓ Yes 2	ned?	death?	
tal Rec :ian: The l certificate l		25. Was case referre	ed to medical				26.Plac	ce of Death (Ch	neck only o	122			
Vital F ysician: his certiff director,	o Be	examiner?	2 No	Hospital: 1 Inpat	ient 2	ER/Outpatient	3 00A	Other <sub>4</sub> N	lursing Ho		Residence		ner:
n of Vital Records, ling Physician: The law requir After this certificate has been s funeral director, page 2 should	<b>—</b>	27. Manner of Death		28a. Date of In (Month, Day Feb 23, 200	jury Year)	28b. Time of In	, ,	jury at Work?	Occ	. Describe h	ow injury auto st	occurred ruck fixed	d objects
ion tendir eath. tor: A	atio	1 Natural 2 Accident	5 Pending Investig	otion		2106 hrs		Yes 2 V No	D				Rural Route Number, City
Division tal or Attendi rs after death.	Certification	3 Suicide	6 Could no	ot be 28e. Place of		home, farm, stree	t, factory, office	building, etc.	28f.	or Town, St	treet and ate)	& Alton S	treet, Capitol Heights, n
Divisior Hospital or Attend 4 hours after death Funeral Director: tely filled in by the	Ser	4 Homicide 29a. Certifier		ician: To the best of			ad at the time	date and place					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Medical	(Check only one) 2	Certifying Phys Medical Examii	ner: On the basis of ex	amination	and/or investigati	on, in my opinio	on, death occur	rred at the	time, date a	and place	, and due to	the cause(s)
To with with com	Med	29b. Signature and t	title of certifier	and manner states	3		29c. Lice	nse number			29d. Dat	te signed (A	Month, Day, Year)
(R)		hi	1 20	, MP			0.0	C.M.E.			Febru	ary 24, 2	008
AD .				no completed cause of		m 23a)	D.W.	MD 0400	1				
9		Ling Li, MD		Medical Examin		1 Penn Stree	t, Baltimore	2120°					
S Regis	tate	1. 1. 1. 1. 1. 1.	ZUU0	32. Regist	rar's Signa	all!							
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			1 - For State Registrar	State of	Maryland		artment of rtificate of		and Mental Hygi	ene ()	08	08098	3
	Physici	ian	1. Decedent's Name (First, Midd.						2. Date of Death Month		Year_	3. Time of Death	
	/Medi		Suzanne	Shirey					Febuary	1		10:00 p	M
	Examir	ner	4a. Facility Name (If not institutio				4b. City, Town,	or Location o	f Death	4c. Count	ty of Death		
	F		Ravenwood Luth 5. Social Security Number		ge . Age (In yrs. la	st hirthday)	Hagerst If Under 1 Year		24 Hrs. R Date of Birth	Wash	ingto	n lace (State or Fore	ian
	Funeral Director		213-24-8587	1 □ M 2 💢 F	79	Yrs.	Months Days		8. Date of Birth (Month, Day, March 28	Year) 1928	Cour	vland	gii
	Р.		Usual Residence of Decedent	1					rial Cir Ze	7 1720	mar	yland	
	arylar show	-	10a. State 10b. County	,	10c. City,	, Town or Lo	cation				1	Od. Inside City Lim	
	Pe M.	ecto		ington		Maug	ansville		1			1 □ Yes 2√∑1	40
	a or 3	Dir	10e. Street and Number				10f. Zip Code		10	g. Citizen of		itry?	
	ns 23	eral	13823 Weaver A	Venue 12. Was Deced	ent Ever in U.S	13		767 Hispanic Orio	nin? (Specify Yes or No-	US.	A ice - Americ	an Indian	
(O	r iter	Fun	1 Never Married 2 Mar	nied 1 Tyes 2	es? ![X] No				gin? (Specify Yes or No- , Puerto Rican, etc.)		ack, White,		
03	rai', o	l by	3 ₹ Widowed 4 ☐ Divorced	If Yes, Give Year or Dat	es:		1 ☐ Yes 2 🌠 No	Specify:		Speci	ify: Wh	ite	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show ta Madical Examiriar must be notified at	Completed by Funeral Director	15. Deceder (Specify only highs	nt's Education est grade completed)		16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	upation e during most	of working	6b. Kind of I	Business/In	dustry	
121	vithin ne. han	μp	Elementary/Secondary (0-12)	College (1-	tor 5+)	life.							
	Hygie Hygie ther t	e Co	12 17. Father's Name (First, Middle,	Last) 2			Homemak		r's Name (First, Middle, N	Her o		ne	
an	d be antal ced o	To Be	Earle H. Light	_					•	.2.00.1 00///2			
Maryland	2 should be filed within 72 hours after dea and Mental Hyglene. Is marked other than "natural", or items aumatic event, I'm Madical Examinating	F	19a. Informant's Name/Relations			19b. Mailir	ng Address (Stree		zel Uhler r or Rural Route Number,	City or Town	n, State, Zip	Code)	
Š	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural; or items 23e or 28a-f show any injury or other traumatic event, it a Mardical Examini or institle notified at once.		James J. Shire	v. Jr S	on	218 (	Carrison	Court	Ashury No	na Torri	noar Al	อกา	
<b>Baltimore</b> ,	of He of He litem		20a. Method of Disposition	•	20b. Pla	ace of Dispo	sition (Name of natory or other pla	ace)	, Asbury, No	0c. Location	- City or To	own, State	
Ĕ	Pag nent ant: if ury o		1 ☐ Burial 2 M Cremation  1 ☐ Donation 5 ☐ Other (5	Specify)			vn Crema		3/1/08 P				(i)
Salt	eparti eparti porti ny inj		21. Signature of Euneral Service	Licensee	7 `		Name and Addr		Minnich E				7.
_	40 E 8 9		Dan	11/10/	Unni				Blvd. Hagers		Mary		0_
			23a. Enter the disease, o shock, or heart failure. List	r complications that car only one cause on each	used the death. th line.	Do not ent	er the mode of dy	ring, such as	cardiac or respiratory arre	st,		Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a Me	slo de	pple	Stu	Supr	damo			Means	
1	/Medical Examiner		Todataly in addition	Due to (d	s a conseque	ence (f):	00100	1					
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	cate be executed oblysician and the burial-transit	Examiner	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>S</b> .									
oʻ	ate be executed hysician and the burial-transit	Exa	resulting in death) Last	c. Due to (o	r as a conseque	ence of):							
8760,	ate be nysici he bu	dical		d									L Drille
9	ertific ling pl	Med	IF FEMALE:										
Вох	death certifica e attending ph id for use as th	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?		h 2 ☐ Fetalo	death 3□	Ectopic pregnance	су		1	ate of delive	nry Day Year	53
	0 00	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknov	nt at time of dea n	atn 5L	Other (specify) _						
صِّ	The law requires that the site has been signed by the page 2 should be detache	y Ph	Part II. Other significant conditi	ons contributing to dea	th but not result	ting in the u	nderlying cause g	iven in Part I.	23e. Did tob	acco use cor	ntribute to th	ne cause of death?	
rds,	quires n sign ald be	d by							1 □ Ye	s 2 No	3 Prob	ably 4 Unknow	wn
of Vital Record	aw requir as been s 2 should	Completed							24a. Was an		. Were auto	psy findings availal	ble
R	The lay ate has bage 2:	mo							autopsy perform 1 ☐ Yes 2	ed? Z No	death?	inpletion of cause of Mail No	Я
ita	ysician: The lis certificate he director, page	Be	25. Was case referred to medica examiner?	ı				26. Place	of Death (Check only one	<del>\</del>		<del></del>	
of V	Physician: this certific ral director,	2	1 ☐ Yes 2 No			R/Outpatier	t 3 DOA	ther: X Nur	rsing Home 5 Resider	nce 6 □Ot	her (Specif	1)	
n o		on:	27. Manner of Death 1 Natural 5 ☐ Pendir		Injury Day Year)	28b. Time of Injury		ork?	28d. Describe how	w injury occu	ırred		
isio	ttendi death. ctor: A / the fu	icat	2 Accident investi	not be 380 Bloco o	f laiunt . At ham	no form at-		]Yes 2□N	28f. Location (Str	oot and Num	bor or Pur	I Pauta Numbas	
Division	I or Attencatter death Director: Jin by the	Certification;	4 ☐ Homicide determ	building	, etc. (Specify)	iie, iaim, str	eet, factory, office	3	City or Town,		ibei di Agre	i noute ruinber,	
	Hospital 24 hours Funeral etely filled		29a. Certifier 1 Certifyin	ng Physician: To the b	est of my know	rledge, deatl	occurred at the t	time, date and	d place, and due to the ca	use(s) and m	nanner as st	ated.	
		edical	(Check only 2 Medical one)	Examiner: On the bas and manne	is of examination	on and/or in	estigation, in my	opinion, deat	h occurred at the time, da	te and place	, and due to	the cause(s)	
	within 2 To the comple	M	29b. Signature and title of certifie	0 41			29c. Licen	se number	29	d. Date sign			
1	18-		Mayen	y mady			D'	2836	5	2-2	9 08		
O	-2		30. Name and address of person	who completed dause	of death (Item 2	23a) (Type,	Print)		Cl 1	6/20	. X -	i	
			31. Date filed (Month, Day, Year)	1 32. R	V+7/1	5	68 m	ill	ruel-	reig	rec	190	
	Sta Registr		MAR 0		acrai s signatu	4 1	Sachs				•	1140	
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**Funeral** Director

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To Be Cor	25. Wa
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	For State Registrar		State o	f Marylan		artment of F rtificate of I		d Mental H	ygienę Reg. No.	2008	08099	
- 10	Decedent's Nam	ne (First, Middi	e, Last)					2. Date of D	eath		3. Time of Death	
an :al	HERMA	AN F. S	EITER					FEBRUA	RY Day	Year 19 2008	4:40 AM	
er	4a. Facility Name (	If not institutio	n, give street and nur	mber)		4b. City, Town, or	Location of D	eath	4c.	County of Death		
	WILLIA	AM HILL	MANOR				STON			TALBOT	7	
	5. Social Security N		6. Sex <b>X</b> M 2 ☐ F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, E	ay, Year)	Cou	place (State or Foreign intry)	
	214-20-0		10	85	Yrs.			JUNE 4	,192	2 MAR	RYLAND	
	Usual Residence o 10a. State	10b. County		10c. Cit	y, Town or Lo	cation					10d, Inside City Limits	
tor	MD	T'A	LBOT		W.	ASTON					1 ∐Yes 2X No	
rec	10e. Street and Nu	_	шьох			10f. Zip Code			10g. Citizen of What Country?			
Funeral Director	28420 (	28420 CATALPA POINT RD				21	601					
nera	11. Marital Status	JALLANII Z	12. Was Dece	edent Ever in U.		Was Decedent of H	ispanic Origin	? (Specify Yes or N	lo-	14. Race - American Indian,		
	1 □ Never Marı 3 □ Widowed		If Yes, Giv	2 □ No ⁄e	1	lf Yes, specify Cuba 1 □ Yes 🌠 No	Specify:	deno Rican, etc.)		Black, White	, etc. HITE	
Completed by	(Spe	15. Deceder cify only highe	nt's Education st grade completed)		i (Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of	working	16b. Ki	nd of Business/li	ndustry	
omp	Elementary/Second 12	ondary (0-12)	College (1	I-4or 5+)		ESIDENT/C				RETAIL		
Be C	17. Father's Name	(First, Middle,	Last)					Name (First, Middl	e, Maiden			
To B	FREDERIC	ም ርቱፐጥ	TETO OTTO				EM	MA BOSSE				
-	19a. Informant's N				19b. Mailir	ng Address (Street		or Rural Route Num	ber, City o	r Town, State, Z	ip Code)	
	MARY B.	SEITER	/WIFE		2842	O CATALPA	POINT	RD., EAS	TON,	MARYLAN	D 21601	
	20a. Method of Dis					sition (Name of natory or other place	e)	Date	20c. Lo	cation - City or T	own, State	
	1 ( <b>X</b> Buria) 2 4 □ Donation		3 □Removal from Specify)		ODLAWN	MEMORIAL	PARK	2/26/2008	EAS	STON, MA	RYLAND	
	21. Signature of Fi	uneral Service		E 0 3.	F		ELFENB	EIN & NEV			HOME PA	
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									21601	Approximate	
	Immediate Cause	(Final	only one cause on e	acri line.	1	rul mine	$= \Omega$	wal			Interval Between Onset and Death	
	disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):								2000)			
									11 moute			
ner								1				
ami	Cause (Disease or that initiated events	r injury s	c									
dical Examine	resulting in death)	Last	Due to	or as a conseq	uence of):							
lica			d									
Me	IF FEMALE:		220 Hyan au	nome of present	2001				- [			
ian/	23b. Was decedent in the past 12		1 ☐ Live b	come pf pregna pirth 2 ☐ Feta	ideath 3□	Ectopic pregnancy			2	23d. Date of deliver Month	very Day Y <i>e</i> ar	
ysic	1 ☐ Yes 2 l 9 ☐ Unknown		4∐Pregr 9∏Unkn	ant at time of down	eatn 5∟	Other (specify)					•	
문			ons contributing to de	eath but not resi	ulting in the u	nderlying cause give	en in Part I.	23e. Dio	tobacco u	se contribute to	the cause of death?	
Completed by Physician/Me	End.	Stoke	Kline	PD4	leane					No 3□ Pro		
etec		0						04- 144-		0.45 - 14		
шb								— 24a. Wa	s an opsy formed?	prior to or death?	opsy findings available ompletion of cause of	
ပ္ပ	25 Was seen set-	read to madica	1				00 =:	1□ Yes	2-1 No	1 ☐ Yes	2 □ No	
Be c	25. Was case referexaminer? 1 ☐ Yes 2 ☐	/	Hospital:	Innation: 0 T	ER/Outpatien	. all Doa Oth	ar.	Death (Check only				
٥	27. Manner of Deat		28a. Date		28b. Time of	IL 3[] DOA	4 L Nursii	ng Home 5 ☐ Re			ify)	
ioi	1 Natural	5 Pendir	ng (Mon	th, Day Year)	Injury	Wor	k? Yes 2 ∐ No	Lou. Dodding	, now injur	y doddiired		
fica	2 ☐ Accident 3 ☐ Suicide	6 Could	not be	of injury - At ho	ome, farm, str	eet, factory, office		28f. Location	(Street an	d Number or Ru	ral Route Number,	
erti	4 ☐ Homicide	deterri	buildi	ng, etc. (Specif	y)				own, State		,	
Medical Certification:	29a. Certifier (Check only one)		ng Physician: To the Examiner: On the b									
Mec	29b. Signature and	title of certifie		- Julious		29c. Licens	e number		29d. Dat	e signed (Month	, Day, Year)	
	▶	selle	an Ital	oal >	1 MT	DO	2871	5	S	-/19/0	8	
			who completed caus									
			OOD, JR M.	.D. 501	DUTCH	MANS LANE	, EAST	ON, MD 21	601			
te ar	31. Date filed (Mor	EB 2 2	2008	egistrar's Signa	1 Sou	Med .						
001	<u> </u>	LU & &			1							

Sta Regist

20+VA

08-01782 Nancy Carter Sto	ne	Please Type or Print in Black Indelible Ink. Ensure All Copic State of Maryland / Department of Health and Mental F	<b>es Are Le</b> lygiene	egible	200	8 0810	
		1- For State Certificate of Death		Reg. No.			
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last) Nancy Carter Stone	2. Date of De Month March 2,	Day 2008	Year	3. Time of Death 1750 hrs	
<b>(</b> ************************************		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat Laurel Regional Hospital  Laurel		P	rince George	e's	
Funeral Director	Director 182-40-4901 1 Months Days Hours Min. August 22,194						
w any		Usual Residence of Decedent  10a. State				10d. Inside City Limits 1 Yes 2 No	
Maryland or 28a-f sho	Director	10e. Street and Number 3551 Corridor Market PL Suite 400–20 20724		10g. Citi	zen of What Cou		
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. fant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Funeral D	11. Marital Status 1 Never Married 2 Married Proces? 1 Yes 2 No			14. Race - Amer White, etc.	ican Indian, Black, nite	
nours after	ā	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		16b. I	Specify: Kind of Business/	Industry	
5-0036 led within 72 l Hygiene. other than ",	ompleted	Elementary/Secondary (0-12)  College (1-4 or 5+)  Cashier  17. Father's Name (First, Middle, Last)	- (Cianh Miladia	Maidan	retail		
15-C	ပ	Tod:	th Larse		Surriame)		
MD 2121 d 2 should be fi tht and Mental n 27 is marked numatic event,	To Be	Seward Carter Edit  19a. Informant's Name/Relationship (Type, Print) Erin K. Meara/daughter 19006 Breezewood Terr	Rural Route N	umber, C	ity or Town, State )3 ,Green	e, Zip Code) belt MD	
Baltimore, MD 21215-00 pernit. Pages I and 2 should be filted wif Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the Me.		Metropolitan Crem. 20	ch 5,	- 1	Location - City or exandria		
Baltimore, permit. Pages I as Department of He Important: If ite injury or other tr		4 Donation 5 Other Specify:  21. Signatu of neral Service Licensee  22. Name and Address of Facility Be	eall Fu	neral e MD	Home 20715		
Physician /Medical		23a. Part I. Enter the disease, or course tions that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause of each line.  Immediate Cause (Final disease a Amphietamine intoxication	or respiratory	arrest, sho	ock, or heart	Approximate Interval Between Onset and Death	
⊤xaminer		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.					
	Examiner	If any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated C.					
ecuted and transit	al Exa	events resulting in death) Last  Due to (or as a consequence of):  d.  d.	00 1				
0, be exc sician			Us amh		d. Date of delive		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 ✓ No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic preg 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	nancy	23		y Day Year	
P.O. B es that the d signed by the	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Hypertensive Cardiovascular Disease		_		the cause of death?	
of Vital Records, P.O. Bo. ng Physician: The law requires that the deat Nher this certificate has been signed by the at neral director, page 2 should be detached for	Completed	Typertensive Cardiovascular bisease		topsy rform <u>ed</u> ?		utopsy findings available completion of cause of	
tal Rection: The Centificate	Be C	25. Was case referred to medical 26.Place of Death (Chec					
Vita hysici this c	To B	1 V Yes 2 No	sing Home 5		ence 6 Oth	er:	
1 of ding Pl After funeral		27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?  1 Natural 5 Pending 3/20/08 1 Tend 5.18 pm 1 Yes 2 X No			jury occurred		
SiOI Attender r death ector: by the	cati	2 Accident Investigation 3/20/00 FIRE 5:10 pill   Investigation are street factory office building etc.	Unknown 28f. Locatio		and Number or R	tural Route Number, City	
Division of <sup>1</sup> To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Certification:	Suicide 6 A Could not be determined (Specify) Residence	4705 Li	n, State) NCOLN	Ave, Belts	sville, MD	
To the Hos within 24 h To the Fur	Medical	29a. Certifier (Check only one)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	nd due to the c d at the time, d	ause(s) a ate and p	nd manner as sta lace, and due to f	ited. the cause(s)	
F . W F 8	Me	29b. Signature and title of certifier  29c. License number  O.C.M.E.			Date signed (March 3, 2008	onth, Day, Year)	
		30. Name and address of person who completed cause of death (Item 23a)  Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, I	MD 21201		,		
	ate	31 Days flyed (Menth: Day Year) 32. Registrar's Signature					
Regist	(E)						

08-01753		Please Type or Print in Black Indelible				gible.	o noin
Sherry Sutherlar		State of Maryland / Department		d Mental Hy	giene	200	0 0010
DI. · ·		I- For State Registrar 1. Decedent's Name (First, Middle,Last)	or Death	· · · · · · · · · · · · · · · · · · ·		eg. No.	
Physicia Medical Examin		Sherry Lynn Sutherland		T.	2. Date of Deat Month	Day Year	3. Time of Death 0755 hrs
<b>₩</b> 3		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or	Location of Death	March 1, 2	4c. County of Death	
¥,		B Street	Lothian			Anne Arundel	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	) If Under 1 Yea	If Under 24Hrs.	8. Date of Bir	th(MM/DD/YYYY) 9. Birt	
Director		217-86-6755 1 M 2 XF 41	Months Day	s Hours Min.	08/01	/1966 Foreig	n <sup>untry)</sup> Maryland
	t	Usual Residence of Decedent			00,01	72300	
w any		10a. State 10b. County 10c. City, Town or Lo				. =	10d. Inside City Limits
Maryland 28a-f show d at once	5	MD Calvert Nort	h Beach				1 Yes 2 XNo
Mary Mary	Je C	10e. Street and Number	10f. Zip Code		1	0g. Citizen of What Cour	ntry?
ITZF after death with the Maryland al", or items 23a or 28a-f she iner must be notified at once	by Funeral Director	3850 Oak Street	20	0714		U.S.A.	
er death with the ', or items 23a	era		Was Decedent of His If Yes, specify Cubar			<ul> <li>14. Race - Ameri</li> <li>White, etc.</li> </ul>	can Indian, Black,
// er dea	歪	1 Yes 2 Y No			,		h i t o
rs afte	à	l or Dates:	Yes 2 X No		ork dono	Specify: W.  16b. Kind of Business/I	hite
2 hou	활		g most of working life			Tob. Kind of Business/i	ndustry
336 thin 7 re. than edica	Completed		waitress			restaur	ant
5-00 ed wi lygier other	डी	17. Father's Name (First, Middle, Last)		18.Mother's Name	(First, Middle, I	Maiden Surname)	-
121; be fill antal F	8	Howard Alvin Sutherland		Cathe:	rine	Eileen Cu	nningham
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland men of Health and Mental Hygiene. Isnit: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	유					nber, City or Town, State	, Zip Code)
nd 2 salth a sm 27	-					MD 20714	T
Ore, es l a of He of Her tu		1 V Burial 2 Cremation 3 Removal from State crematory or	position (Name of ce r other place)		Date	20c. Location - City or	
Lim Pag tment tant:	L	4 Donation 5 Other Specify: Chesapea	ake Highla			Port Repu	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		I	2. Name and Address	s of Facility Rat	ısch Fu	neral Home,	
Physician	-	Bryan G. Ne1bach, MOOOO, per DVR 23a. Part I. Enter the disease, or complications that caused the death. Do not enter					20736 Approximate Interval
/Medical		failure. List only one cause on each line.	or the mode of dying	, 000, 00 00, 000	roopiratory an	ost, shoot, or hour	Between Onset and Death
xaminer	- 1	Immediate Cause (Final disease or condition resulting in death)  a Cardiac Arrhythmia  Due to (or as a consequence of):					
		Sequentially list conditions, b					
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause					
	틩	(Disease or injury that intuated events resulting in death) Last Due to (or as a consequence of):					1
executed an and al - transi		d					
be exe	dical	X UNPENDED X #Z1, perFD, g877 3/12/00	<sub>3 TT</sub> 23a,27,	, per ME g87	8 4/3/08	amh	
68760, certificate be nding physici	§[	IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date of deliver	
certif	lä.	past 12 months?  1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3	Ectopic pregnar	су	Month [	Day Year
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Med	1 Yes 2 No 9 V Unknown g Unknown	Other (Specify)			1	
O. nat the cid by t		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause	given in Part I.		obacco use contribute to	
s, P irres th	d by	-			1 Yes	s 2 V No 3 Prot	ably 4 Unknown
ords v requested should	흥				24a. Was autop		topsy findings available completion of cause of
Cecc The lar ate ha	Completed					rmed? death?	es 2 No
al R	ψ	25. Was case referred to medical	26.Place	e of Death (Check o			
Division of Vital Records, P.O. ral or Attending Physician: The law requires that th its after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	9 0	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpati	ent 3 DOA	Other Nursing	Home 5	Residence 6 🗸 Othe	r: Scene
Ing P	٦	27. Manner of Death  1 X Natural  28a. Date of Injury (Month, Day, Year)  28b. Time	· · ·		28d. Describe	how injury occurred	
ivisior or Attend after death. Director:	ij	2 Accident Investigation		Yes 2 No			*1
Nor A	Certification:	3 Suicide 6 Could not be determined (Specify)	street, factory, office t	building, etc.	28f. Location (\$ or Town, S	Street and Number or Ru State)	ral Route Number, City
ospitz hours innera		4   Homicide		4			
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Atlanding Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ωl	(Check only one) 2 Certifying Physician: To the best of my knowledge, death on one) 2 Medical Examiner: On the basis of examination and/or investi					
To To Con	ĕ-	and manner stated.  29b. Signature and title of certifier	29c. Licens			29d. Date signed (Mo	
		Mario - No Mario	O.C.	M.E.		March 2, 2008	
	+	30. Name and address of person who completed cause of death (Item 23a)					
		Margarita Korell MD. Assistant Medical Examiner 111	Penn Street, B	altimore, MD 2	1201		
	ite	31. Date filed (Month, Day, Year)					
Regist	7-17	BEALT I / (UUU PARAMANA)					

				artment of He		Reg.		08102
. ^	Physici	an	1. Decedent's Name (First, Middle, Last) Alberta Thornton				Day Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give street and number)	4b. Cily, Town, or Lo			2008 4c. County of Dea	8:45 P M
12	LAdiliii	ici	Villa Rosa Nursing Home	Mitchelle	ville		rince Ge	
100	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year		8. Date of Birth (Month, Day, Ye. Oct. 31,		thplace (State or Foreign ountry) rginia
	pu .		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Le	ocation				10d. Inside City Limits
	Aaryla f sho	ō	MD Prince Georges Mitchell					1 ☐ Yes 2√ No
	the 28a-	rect	10e. Street and Number	10f. Zip Code		10g.	Citizen of What Co	
	3a ol	i D	3800 Lottsford Vista Road	20721			U. S. A.	
36	should be filed within 72 hours after death with the Maryland nd Menial Hygiene marked other then "natural", or Itema 23a or 28a-f show imatic event, ina Madical Examinal must be notified at	by Funeral Director	2XZNever Married 2 Married 1 Ves 2XXIVo	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes ※X No	panic Origin? (Spe Mexican, Puerto I Specify:		14. Race - Ame Black, Whit	te, etc.
21215-0036	ithin 72 hou ie. ien "natura i.Medical E	Completed I	15. Decedent's Education   16a Dece   (Specify only highest grade completed)   (Give   life.	edent's Usual Occupations wind of work done dur DO NOT use retired)	on ring most of workin	16b	Kind of Business	/Industry
2	ygien ygien her th	S		mestic		15	Private	Home
Maryland	should be filed vind Mental Hygie marked other tumatic event, ID	To Be	17. Father's Name (First, Middle, Last) Malchi Thornton	1:		(First, Middle, Maid ia Evans	len Sumame)	
Mar	Ith a			ing Address (Street and Gabe Place				Zip Code)
altimore,	Pages 1 ar nent of Hea int: if item: iry or other		20a. Method of Disposition  14 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition cemetary, cre  Ft. Lince	osition (Name of matory or other place)	3/5/0		. Location - City or entwood,	
Baltii	permit. Pages Department of important: if it any injury or o							cal Home PA AD 20748
fr br	Physician		23a. Pah1. Enter the disease or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition					Approximate Interval Between Onset and Death
4.5	/Medical Examiner		Due to (or as a consequence of):		)			
760,	ite be executed lysicien and he burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):					
.O. Box 68	death certifica e attending ph ed for use as th	Physician/Medi		□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	olivery Day Year
<u> </u>	w requires that the de been signed by the s should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given	in Part I.		co use contribute to	o the cause of death?
Division of Vital Records,	The tar ate hes page 2	Completed	0			24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
/Ita	cian: ertific actor.	Be (	25. Was case referred to medical examiner?			(Check only one)		
0	y Physi er this c eral dire	n: To	1   Yes 2 No   Hospital: 1   Inpatient 2   ER/Outpatiel  27. Manner of Death   28a. Date of Injury (Month, Day Year)   Injury   1. Natural   5   Pending   28b. Time of Injury	A Nursing Hon	ne 5 Residence		ecify)	
sion	Attending Physician: It death. ector: After this certifics by the funeral director.	catio	2 Accident investigation	M 1 ☐ Ye	s 2 No	201		
2	는 # 는 c	Certification:	4 Homicide determined 288. Place of injury - At nome, farm, st building, etc. (Specify)			City or Town, Si	tate)	lural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deat control on the basis of examination and/or in and manner stated.	ih occurred at the time, ivestigation, in my opin	, date and place, a nion, death occurre	and due to the cause ed at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the l within 2 To the I complet	Σ	29b. Signature and title of cerifier	29c. License r			Date signed (Mon	
			by Com	70327	261	0	2-29	-1008
/	(3)		30. Name and address of person who completed cause of death (Item 23a) (Type,		LANCE	- m 2	6706	
	Sta Registr		31. Date filed (Month, Day, Year)  FEB 2 9 2008  32. Registrar's Signature	ı				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla	nd / Depa		Health and	Mental Hy	Reg. No.	08103
	Physic /Medi		Decedent's Name (First, Middle, Las.     LOIS E. THOMAS					2. Date of Dea Month FEBRUAL	Day Yea	
	Examir	er	4a. Facility Name (If not institution, give CHESTER RIVER HOS				or Location of Deat ERTOWN	h	4c. County of De	ath
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs	. last birthday)	If Under 1 Yea	r If Under 24 Hrs.	8. Date of Birti (Month, Da)	KENT 9. B	inhplace (State or Foreign
	Director		Usual Residence of Decedent		83 Yrs.	Months Days	s Hours Min.	MAY 28,	1924 WI	EST VIRGINIA
	with the Maryland a or 28a-f show Lea notified at	Director	MARYLAND QUEEN A		ity, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 XNo
	with 1	Dir	10e. Street and Number	DOAD		10f. Zip Code			10g. Citizen of What	
	death	Funeral	1404 LITTLE CREEK  11. Marital Status	12. Was Decedent Ever in U	J.S. 13.		<b>21619</b> Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No-	14. Race - An	nerican Indian,
9036	72 hours after natural', or ite ilcal Evamine	þ	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:	1	f Yes, specify Cul		o Hican, etc.)	Specify: W	
21215-0036	c * #	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	16a. Deced (Give life.	dent's Usual Occu kind of work done DO NOT use retire	upation e during most of wor ed)	king	16b. Kind of Busines	ss/Industry
	D D .		47 5-4 - 1- 10 - 4 - 4 - 4 - 4	4	NURSE	<u> </u>			MEDICAL	
Maryland	g m p >	To Be	17. Father's Name (First, Middle, Last)  THEODORE DALTON				ETHEL I	DALTON	Maiden Sumame)	
Mai	2 es es es		19a. Informant's Name/Relationship (T)						r, City or Town, State	
	of Health Item 27		MERRILL THOMAS, J. 20a. Method of Disposition	20b.	Place of Dispo	sition (Name of			MARYLAND 2 20c. Location - City of	
ē	Pages ent of nt: If I		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	-	natory or other pla	l l	UARY 28 2008		
Baltimore,	permit. Pages Department of I Important: If It eny Injury or o		21. Signature Funeral Sentice Licens		/ 22 FE	. Name and Addr	ess of Facility	N AND NEV		LLE, MARYLANI
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the dealer cause on each line.  Due to (or as a consec	th. Do not enter	er the mode of dy	ing, such as cardiac	or respiratory ari	rest,	Approximate Interval Between Onset and Death
8760,	ite be executed lysician and ne burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.)  Due to (or as a consect.)	quence of):	Maak	domina	l viscu	\$	dejs
P.O. Box 68	res that the death certifical igned by the ettending phi be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2NNo 9 Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3	Ectopic pregnand Other (specify)	гу		23d. Date of d Month	elivery Day Year
rds, P	w requires that been signed be should be det	þ	Part II. Other significant conditions co	ntributing to death but not res	sulting in the ur	nderlying cause gr	iven in Part I.			to the cause of death?  Probably 4 Unknown
Records,	hysician: The law requires that the his certificete has been signed by th I director, page 2 should be detache	Completed						24a. Was a autops perfor	sy prior to med? death?	
Vital	ilan: ortifice ctor, p		25. Was case referred to medical examiner?				26. Place of Dea	1 ☐ Yes :		s 2 No
ot o	Physician: this certifice ral director, p	၉	1 ☐ Yes 2 No	lospital: 1 Inpatient 2	ER/Outpatient	1 3□ DOA O	her: 4 🗆 Nursing H	ome 5 🗆 Reside	ence 6 Other (Sp	ecify)
Division o	ding h. After fune	Certification;	27. Manner of Death  1 S Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 1	ork? ]Yes 2∐No		ow injury occurred	
2	2 = = -		4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	(y)			City or Town		
	To the Hospital or within 24 hours efte To the Funeral Dir completely filled in I	Medicai	29a. Certifier (Check only one)  Cartifying Physical Cartifying Physical Examination	sician: To the best of my kno nar: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the ti estigation, in my	ime, date and place, opinion, death occur	and due to the c red at the time, d	ause(s) and manner a ate and place, and du	as stated. se to the cause(s)
	5	Σ	29b. Signature and title of certifier	Yearslay,	w		se number		9d. Date signed (Mor	
	9		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type, F Dusch	mans /	ane, Ea	sfon, M	2: <b>2</b> 8:0 D 21601	
	Sta Registr	E	31. Date filed (Month, Day, Year)	Jan Magainer a digita	ature	A				

Registrar DHMH 17 Rev 1/2001 30. Name and address of person who completed cause of Geath (Item 23a) (Type, Print)

Now Year)

31. Date filed (Month, Day, Year)

FEB 2 8 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 10:10 PM Lois J. Taylor 02 23 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Coastal Hospice at the Lake Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 X F 220-52-8226 58 **Director** 03/13/1949 <u>Maryland</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 Yes 2 No Funeral Director MD Somerset Westover 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or edical Examiner must be i 8541 Charles Layfield Road 21871 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natu any injury or other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Bookkeeper State of Maryland Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 Is marked of Delmas Price Attie Chappell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Everett Taylor/Husband 8541 Charles Layfield Road, Westover, MD 21871 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Asbury U.M. Cemetery 02/27/2008 Mount Vernon, Maryland 21. anature of Funeral & rvis Livensee 22. Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, MD Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. mmediate Cause (Final disease or condition resulting in death) AMYOTROPHIC LATRRAL Physician SCLRROSI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Physician: The law requires that the death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy perform 1∐ Yes 2√EPNo 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 Ro Medical Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 5 Pending investigation To the Hosp.....
within 24 hours after death.
To the Funeral Director: Aft Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only / one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar CEHULAM WARIS

31. Date filed (Month, Day, Year) FEB 2

DHMH 17 Rev 1/2001

ORIGINAL

HOSPIC

32. Registrar's Signature

SALISBUMY and 21802

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

COASTAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** FEBRUARY 21 2008 4:05AM ETHEL ALLEN UBER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner TALBOT EASTON WILLIAM HILL MANOR If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
OCT 23, 1922 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 X F 85 Director 218-16-8346 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show Ħ 1★TYes 2 No Director notified EASTON TALBOT MD 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or pe 501 DUTCHMANS LANE 21601 USA death v Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. hours after 1 Never Married 2 Married r than "natural", or i Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ò WHITE 3 ▼ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12 0 permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, # 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BENNETT C. ALLEN MARY HARRINGTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14119 OLD WYE MILLS ROAD, WYE MILLS, MD 21679 STEPHEN B. ALLEN/NEPHEW Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 2/25/2008 WYE MILLS, MD OLD WYE CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA C.F.S.P. 21. Ustrough. Joseph 200 S. HARRISON ST., EASTON, MD 21601 Approximate Interval Between Oaset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) secondo **Physician** /Medical Due to (or as a consequence of): Examiner Williaster Steel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed Due to (or as a consequence of) burial Box 68760. attending physician Physician/Medical the as asn 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) □Yes P.O. 9□Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 TYes 2 No 21 No )ernenta Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2□No 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident hin 24 hours a er deat the Funeral Lirector: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

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State Registrar

JR. 2008

M.D.

30. Name and address of person who completed cause of death (1 em 23a) (Type, Print)

WILLIAM H. WOOD,



501 DUTCHMANS LANE, EASTON, MD 21601

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** February 27, 2:45 aM 2008 Peggy A. Watts /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Genesis Eldercare-Layhill Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 79 Yrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 577-34-2487 1 M 20 F Oct. 20, 1928 Virginia Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10h County 10a State rel', or itema 23a or 28a-f ehow Examinar must be notified at 1 ☐ Yes 2x No Maryland Montgomery Wheaton Direct 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20902 4027 Adams Drive within 72 hours after death iene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes Synon No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩ No Specify: Specianite Ď 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry The Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) other than Law Office Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental F ie marked of permit. Pages 1 and 2 should be Department of Heelth and Menta Importent: If Item 27 Ie marked any liqury or other traumatic events. Margaret Capes Richard Andrews 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4027 Adams Drive, Wheaton, MD 20902 James S. Watts/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State March 3, 2008 Silver Spring, Maryland Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Gervice License 22 Name and Address of Eachity Francis J. Collins Funeral Home Inc. University Blvd, W, Silver Spring, MD 20901 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest diuse on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one d Immediate Cause (Final rans Tou **Physician** disease or condition resulting in death) ) au ceo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of) Examiner physicien and s the burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed: 1 Yes 2 No 250 No certificete 1 ☐ Yes director. 25. Was case referred to medical Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Feath 28b. Time of Certification: Attending 5 Pending Natural 1 ☐ Yes 2 ☐ No death. investigation A ☐ Accident filled in by the Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hours after the Funeral Dire Hospitel 1 Certifying Physician: To the best of my knowledge death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Fune completely fi (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier wit D38262 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Research BLVD S. T. A 2401 MW 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 28 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Cecile YOURMAN Feb. 27, **Physician** 2008 10:31 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 13, 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1□M 2□XF 89 188-12-9356 **Director** Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits Director 1 X Yes 2 □ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with thent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 2 ury or other traumatic event, the Medical Examiner must be n United States 4750 - 41st Street, NW #508 20016 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ white 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Golda Rosenberg Edward Weinman ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4750 - 41st Street, NW, #508, Washington, DC 20016 Howard Yourman, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If iter any injury or ott once. 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mt. Lebanon Cemetery 02/28/08 Adelphi, MD 21. Signature of June 1 Se vice Licen. forchings of the Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner 10 Days Stroke Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Division or Vital Records, P.O. Box 68760, 🕁 Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 💢 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury To the Hospital or Attendi within 24 hours after death.
To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Acrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one)

lourman,

2/37/08

State Registrar

29b. Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jose Merino-Juarez, M.D., 8600 01d Georgetown Road, Bethesda, MD 31. Date filed (Month, Day, Year) FEB 2 8 2008



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2132 M **Physician Helen** P. Anderson 9008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE ST AGNES MI HOSPITAL N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
AUG 7, 1919 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Hours Days 1 ☐ M 2 👿 F Yrs. 88 Maryland 217-07-4903 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 'al", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 No Director N/A Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21227 3310 Benson Avenue, Apt. 214 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 77 is marked other than "ne traumatic event, the Medice (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home 12 should be filed w n and Mental Hygier is marked other th Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Alfred Lorenz Alice ပ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catonsville, Maryland 21228 203 Altamont Avenue Patricia E. Foster, niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Meadowridge Mem. Park 03/14/08 Elkridge, Maryland 22. Name and Address of Facility MacNabb Funeral Home, P.A. 21. Signature of Funeral Service Licensee George MacNabb E Man Al 301 Frederick Road Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician Physician/Medical asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Ulinknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has performed 2NNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 Tes 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 🛂 No 2 Accident To the Hospital or Attence within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date/signed (Month, Day, Year) 29c, License number

Maryland 21215-036

Baltimore,

Division or Vital Records, P.O. Box 68760,

State Registrar 31. Date filed (Month, Day, Year) 2008



St. Agnes Hospital

900 S. Caton Ave. Baltimore, MD 21229

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician**  $P^{M}$ Marion Lenoria March 11 2008 2:20 Aver /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Conv. Center Crofton Anne Arundel 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 1 1 F Yrs 094-07-5654 89 Director 07-01-1918 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. r 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 ☑ No Director MD Anne Arundel Hanover 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or 7673 Clark Road 21076 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: by 3X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ George W. Ayers Goldie Fuller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Mrs. Bonnie M. Werre - daughter 7673 Clark Road Hanover, MD 21,076 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory 3/13/08 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP. 7250 Washington Blvd. Elkridge, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Mich /Medical consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed burial-transi resulting in death) Last uence of) Division or Vital Records, P.O. Box 68760 Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) 2 □ No □Yes 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑No 24a. Was an was autopsy performed? has certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No ို 2 ER/Outpatient 3 DOA 4 Nursing Home this 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Certification: To the Hospital or Attending 1 Alatural 5 Pending investigation Injury 2 No 1 Tyes death. 2 Accident the Director; 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Scriffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of pe rson who completed cause of death (Item 23a) (Type, Print) State 2008 Registrar

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	1 - For State Registrar	Certificate of Death	Reg. No.2 0 0 8 0 8 1 1
sician edical	1. Decedent's Name ( <i>First, Middle, Last</i> )  James Lee Arnold		2. Date of Death Month Day Sear 12:20 P
miner eral tor	236-46-1745 <sup>1</sup> ∑M <sup>2</sup> □F	4b. City, Town, or Location of Death Perry Point (In yrs. last birthday) Wonths Days Hours Min.	8. Date of Birth (Month, Day, Year) July 3, 1932  4c. County of Death  County  9. Birthplace (State or Foreign Country)  WEst Virginia
4	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limit
Director	MD Harford	Edgewood	1 □Yes 2√∑N
ral Dire	601 Mulberry Lane	10f. Zip Code 21040	10g. Citizen of What Country? USA
To Be Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Armed Forces?  1 □ Yes 2 □ If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puèrfo	ecify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or to the control of	16a. Decedent's Usual Occupation (Give kind of work done during most of worki life. DO NOT use retired)	
Con	12 4 17. Father's Name (First, Middle, Last)	accountant	financial  (First, Middle, Maiden Surname) unk
To Be	Charles Arnold	to, Mother's Name	e (Pist, Middle, Malden Surname)
	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Rura	
	Elizabeth Arnold/spouse 20a. Method of Disposition		Date 200. Location - City or Town, State
	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🕅 Donation 5 ☐ Other (Specify)	cemetery, crematory or other place)	
ouce.	21. Signature of Euneral Service Licensae Roffald S. Wade, Dir	ector State Anatomy Board  Baltimore, MD 2120  Ithe death. Do not enter the mode of dying, such as cardiac of	
후 발명 by Physician/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	tatic Smalle Carcino a consequence of): a consequence of):	ma of Lung Unknow
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	23d. Date of delivery  Month Day Year	
	Part II. Other significant conditions contributing to death b	ut not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unkno
0			24a. Was an autopsy performed? 1 ☐ Yes 2 No 124b. Were autopsy findings availa prior to completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 No
Medical Certification: To Be Com	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 10 Natural 5  Pending investigation 2  Accident 3 Suicide 4 Homicide  28a. Date of Inju (Month, Da.)  28a. Date of Inju (Month, Da.)	ry Year) 28b. Time of 28c. Injury at Work?  M 1 Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N	me 5 Residence 6 Other (Specify)  28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State)
Medical Ce	29a. Certifier (Check only one)  1X CertifyIng Physician: To the best 2 Medical Examiner: On the basis on and manner sta	of my knowledge, death occurred at the time, date and place, f examination and/or investigation, in my opinion, death occurrated.	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)
Me	29b. Signature and title Sizertifie	29c. License number  D Zo 398  eath (Item 23a) (Type, Print)  Naryland Nealth Care Sys  ar's Signature	29d. Date signed (Month, Day, Year)
	1 1/2 11 // 1/1/1	W) V C0 270	$\mathcal{C}(\mathcal{C}, \mathcal{C},

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month 4:01 P M Phyllis Lucy Garron Armstrong March 9, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1713 Sea Pine Circle Severn Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X F Director Jan 16, 1946 438-62-6983 62 Louisiana Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Maryland| Severn 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1713 Sea Pine Circle 21144 United States filed within 72 hours after death v Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No q Specify: 3 ☑ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry US Department of College (1-4or 5+) 5+ Elementary/Secondary (0-12) the Public Trust Officer Housing 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) in and 2 should be fill Health and Mental H Be ပ Gladys Grace Humphrey Philip Jerome Garron 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important; If Item 27 any Injury or other tr Allyson Armstrong Foster/daughter 308 Juneberry Way Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Memorial
Park 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 3/15/2008 Elkridge, Maryland 21. Sign tu of Funeral Service Lice 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. Thomas unnita 1411 Annapolis Road Odenton, Maryland 21113 23a. Part) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardio Va s cular discase one year /Medical Due to (or as a consequence of) Examiner Cardio myopal Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner physician and the burial-transit diabetes death certificate be execut Due to (or as a consequence of). physician use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day signed by the a 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2▼ No page 2 autopsy perform this certificate director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of eath 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation

Division or Vital Records, P.O. Box 68760, or Attending

Maryland 21215-0036

Saltimore,

funeral After death. after death the f

completely filled in by within 24 hours a

Medical

29b. Signature and title of certification

6 ☐ Could not be

determined

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Yes 2 No

29d. Date signed (Month, Day, Year) March 11,2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

who completed cause of death (Item 23a) (Type, Print)

my 2131

WASHINGTON DC 20037

State Registrar

MAR 13 31. Date filed (Month 2008 gistrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Z U R Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ,<sup>Day</sup>2008 **Physician** Robert A. Allen 9 March 7:15P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Center Towson Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 05.01.1929 Birthplace (State or Foreign Country) **Funeral** Days 220.24.3064 78 Director DÉ Usual Residence of Decedent a or 28a-f show be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1220 Spring Avenue ms 23a c 21237 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death onent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Examiner 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed or than "natur the Medical B 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Social Security Elementary/Secondary (0-12) College (1-4or 5+) Tape Librarian Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ?7 is marked o traumatic ever Lynden Allen Elizabeth Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Michael Allen/Son 1226 Spring Avenue Baltimore, MD 21237 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important; If it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crem. 03.11.08 | Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit CAFA/ Stephen D. Lohrmann, 21. Signature of Funeral Service Licensee P.A. 8717 Green Pastures Dr. Balto., MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COMPLICATIONS FROM CHOLLEYSTIMS **Physician** WEEKS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off-Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, physician the as USe IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by DEMENTIA 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown DIABETES 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an tate has bade 2 s autopsy performe or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HDSPICE 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A 1 Tyes 2 No 2 Accident the f 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 064395

10

31. Date filed (Month, Day, Year) MAR 1 3



State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARCH 10, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 0155AM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brightview Catmin Living 2 Baltmore 5. Social Security Number Year Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 15,1923 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Days Hours 1 ☐ M 2 🖾 F West Virginia Director 220-16-6589 84 Dec. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 313 Glenrae Drive 21228 USA Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 White 1 ☐ Yes 2 基No Specify: by Specify: 3 Widowed 4 Divorced Completed other than "natu vent, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Berkley VanGosen Martha Barney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health of 2749 Deerfield Drive; Ellicott City, MD 21043 Mark J. Bent 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any Injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/15/2008 Woodlawn Cemetery Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licenses 1630 Edmondson Avenue: Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ardige arithy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examine sician and burial-transit attending physician for use as the buria Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 □ Yes 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 10 No 2 □ No 1□ Yes 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical filled in by the funeral director Be 26. Place of Death (Check only one) 1 Yes 2 No 1 🔲 Inpatient 3□ DOA Other: 4 Nursing Home 5 Residence 6 Hother (Special) Certification: To 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

Frederice ld #18, Baldmor 10 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Rea. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician BB MARC /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALT Birthplace (State or Foreign Country) 8. Date of Birth Month, Day, Year) Sex MDM 2 F 7. Age (In yrs. last birthday) If Under 1 Year | If Under **Funeral** Months Days Hours Min. 2/3-12-86 20 Usual Regidence of Decedent Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Madical Experiment must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces

1 Yes No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle) Be 18. Mother's Name (First, Middle, Maiden Surname, 2 19a. Informant's Name/Relation ip (Type. Print) 19b. Mailing Address (Street and Number or Rural Foute Number, City or Town, State, Zip Code) AGINE OF OWSON. 20b. Place of Disposition (Name of cemetery, crematory or other pla 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
UM Luw shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Que to for sels consequence off cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be execul within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2: No 1 ☐ Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1V Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M-D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AAAIIVA I.IACRBM. FOR BRM BLUD 31. Date filed (Month, Day, Year) 32. pegistrar's Signature State Registrar 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear Physician 22:15 p<sup>M</sup> 2008 ALBERT LEE BEAL March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER HARFORD CO BEL AIR If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 XM 2 ☐ F Director 18 1930 MISSISSIPPI 427-44-2705 AUG. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2X No Director NEW JERSEY MERCER HAMILTON 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 186 BERG AVENUE 08610 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 52/58 1 ☐ Never Married 2 X Married 1 ☐ Yes XXNo Specify. Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Maryland 21215-003 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12th grade COOK WATSON ARMY HOSPITAL 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi ပ ALBERT BEAL LAURA MOORE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any injury or other trau Inge M. Beal/Wife 186 Berg Ave., Hamilton, NJ., 08610 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 □ Donation 5 ★ Other (Specify) ENTOMBMENT GREENWOOD CEMETERY 03-15-08 HAMILTON, NEW JERSEY 21. Sign were of Funeral Service Licenses 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Derliara 1206 W NORTH AVENUE, BALTO., M D 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical inscular disease Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine use as the burial-trar attending physician Physician/Medical Seal, Albert (Y) 800 HS 78 Division or Vital Records, P.O. Box IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2□No page 2 has performed? Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 2 Accident Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

			For State of M		epartment of H <i>Certificate of L</i>			giene Reg. No. 200	8 08116
ske	Dhunini		Decedent's Name (First, Middle, Last)				2. Date of Dea		3. Time of Death
	Physicia /Medic		Robert Ernest Bradshaw		41- 631- 7	Lastin of Danis	Oa	39 200 4c. County of D	B 2300 M
)	Examin	er	4a. Facility Name (If not institution, give street and number MEMORIAL HOSPIT		4b. City, Town, or	CRUA-	ac	ALLE	2
	Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birth	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	h y, Year) 9. E	Birthplace (State or Foreign Country)
	Director		235-74-1889 1X M 2 F Usual Residence of Decedent	59 <sup>Y</sup>	rs. Months Bayo		Mar 7,	1948 Ma	ryland
	yland how at		10a. State 10b. County unk	10c. City, Town	or Location				10d. Inside City Limits
	ne Mar 8a-f sl ptified	Director	WV	Ridge					1 □Yes 2√ No
	with the a or 2 the not	Dir	104 Doggrad Drains		10f. Zip Code	0.6750		10g. Citizen of What	Country?
	death ms 23	Funeral	104 Dogwood Drive  11. Marital Status 12. Was Deceden Armed Forces	t Ever in U.S.	13. Was Decedent of Hi If Yes, specify Cuba	26753 spanic Origin? (Spe	ecify Yes or No-	USA 14. Race - A Black, W	merican Indian,
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ If Yes, Give Year or Dates:	(No	1 ☐ Yes 2 No	Specify:	nican, etc.)	Specify: V	
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מַ	e filed al Hygi other vent, t	Be C	17. Father's Name (First, Middle, Last)				e (First, Middle,	Maiden Surname)	.001100
ylar	Menta Menta arked atic ev	TO E	Robert Dale Bradshaw			Helen L			
Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Type. Print) Tricia Bradshaw/spouse	I .	Mailing Address (Street a Dogwood II				e, Zip Code)
ore, i	ges 1 an t of Heal If item 2 or other		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State	20b. Place of	Disposition (Name of y, crematory or other place	1 (	Date	20c. Location - City	or Town, State
аппшо	nit. Pag artmen ortant: injury e.	1	4 ☑Donation 5 ☑ Other (Specify)  21. Signatur Funeral Sprice io see Roman Wade 11.	1000	22. Name and Addres	ss of Facility	655 W	Raltimore	a Street
Ď	Dep Imp any		Manual Wades III		Baltimore,			Darcimor	e Bereet
	76.7		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	ed the death. Do no line.	ot enter the mode of dyin	g, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
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O. DOX	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M		e pf pregnancy 2  ☐ Fetal death at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	<u> </u>		23d. Date of Month	delivery Day Year
dS, T	uires that signed by Id be deta	þ	Part II. Other significant conditions contributing to death	but not resulting in	the underlying cause give	en in Part I.	23e. Did to		e to the cause of death?  Probably 4 Unknown
Hecords	e la has e 2	Completed				<del> </del>	24a. Was autor perfo	osy prior ormed? deat	e autopsy findings available to completion of cause of
Z Z	ician: Th certificate ector, pag	Be Co	25. Was case referred to medical	V - 2-41		26. Place of Deat			/es 2□No
200	hysic this ce al direc	ToE	examiner? 1   Yes 2   No   Hospital: 1   Inpa		tpatient 3 DOA Other	4 Linuising no		dence 6 Other (5	Specify)
	ding P	ion:	27. Manner of Death  1 ★ Natural 5 Pending (Month, E		ime of 28c. Injurniury Worl	y at k? Yes 2 □ No	28d. Describe l	how injury occurred	
UNISION	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Directors. After this certification of the Funeral Directors.  Completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined 28e. Place of in	njury - At home, far etc. <i>(Specify)</i>	rm, street, factory, office		28f. Location (\$ City or Tox		r Rural Route Number,
	Hospital 24 hours a Funeral stely filled	Medical Co	29a. Certifier (Check only one)  1 Certifying Physician: To the bes 2 Medical Examiner: On the basis and manner:	of examination and	, death occurred at the tir d/or investigation, in my c	me, date and place, pinion, death occur	and due to the rred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	ro the	Med	29b. Signature and title of certifier	7	29c. Licens	e number		29d. Date signed (M	
)	1 0		· Coller to	ノ	Da	118985		March	6,2008
			30. Name and address of person who completed cause of	death (Item 23a) (	Type, Print)	NO 0.			D DIENT
	Sta	te	31. Date filed (Month, Day, Year) 32 Regis	trar's Signature	MOKIAL +	TVE., Ci	MOER	LHODIN	D 21502
	Registr		MAR 1 3 2008	strar's Signature	grava )				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 5.10 PM 2000 MARCH Cecilia T. Bayne 6 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE KLARHINGTON MEDICAL ANNE ARUNDE LENTER GLEN BURNIE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 ☐ M 2 🂢 F Feb 21, 216-07-9575 1917 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2☐ No MD Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8735 Piney Orchard Pkwy 21113 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) purchaser bethlehem steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Thommen mary Riley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patricia Thommen/niece 1600 Tieman Drive Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5. Other (Specify) State Anatomy Board 655 W. Baltimore Street 21. Signature of Euneral Service Lice ROTTALD S Baltimore, MĎ 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ECPIPATOR Due to (or as a consequence of): FULMONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery nan 3 Ectopic pregnancy Month ths? Day Year 5 Other (specify) 4□Pregnant at time of death 9 Unknown conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 🖭 Onknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 No 26. Place of Death (Check only one)

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

r 28a-f show notified at

Departmen of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any inJury or other traumatic event, the Medical Examiner must be ı

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

5-0036

2121

Maryland

Baltimore.

Director

Funeral

Completed by

Be

2

The law requires that the death certificate be executed burial-tran physician Physician/Medical the as attending p ed by the a detached f signed t Completed by cate has been siç page 2 should b certificate has

Division or Vital Records, P.O. Box 68760.

Physician:

Hospital or Attending

director.

this After th funeral

within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

Be

Medical Certification: To

IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
Part II, Other significant

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital 1 Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

3□ DOA 2 ER/Outpatient 28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Mann of Death

1 atural

2 Accident 3 Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29b. Signature and title of certifier

6 Could not be determined

29c. License number D45149

Nice

29d. Date signed (Month, Day, Year)

State

13 2008

Dame and address of person who completed cause of death (Item 23a) (Type, Print) 2. Registrar's S

DHMH 17 Rev 1/2001

			1- Stete amend #5 Per	State of Marylan FH G877 3/13	d / Depa /08 <b>о</b> Д	artment of H	ealth a	ınd Mental Hy	giene	08 08 118
			Decedent's Name (First, Middle, Last)					2. Date of De	ath	3. Time of Death
	Physicia /Medic			Katherine	Biddin	ger		MARC	H 07 2	008 6 45 AM
1	Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location o	f Death	4c. County	of Death
			Heart Homes at Pi			Odenton	If I ladas C	2414		Arundel
Н	Funeral			7. Age (In yrs. 95	last birthday) Yrs.	If Under 1 Year Months Days	Hours	Min. (Month, Da	, 1912	Birthplace (State or Foreign Country)  Market 1 and
	Director		Usual Residence of Decedent	93				Apr Z1	, 1912	Maryland
	how		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	e Ma 3a-f s	ctol	MD Anne Aru	ndel Ode	nton					1 X Yes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country?
	s 23a	rai	533 Rita Drive	O Was Danidan Sussia II	6 40	21113		-1-0/6	U.S.A.	e - American Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic avant, the Modical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 💢 No	Specify:	gin? (Specify Yes or No , Puerto Rican, etc.)		k, White, etc.
Ö	72 hou	ted	15. Decedent's Educ		16a. Dece	dent's Usual Occupa	ation	of working	16b. Kind of Bu	usiness/Industry
2	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired,	)	or working		
2	led w lygier her th		8		Owner	/Operator		de Nome /Fime Adiaballa	Taver	
anc	htal had other	Be	17. Father's Name (First, Middle, Last)					r's Name <i>(First, Middle</i> zabeth	, Maiden Suman	
7	hould d Mei mark matic	7	Philip Loris  19a. Informant's Name/Relationship (Type	ne Print)	19b. Mailir	no Address (Street a		r or Rural Route Numb	er. City or Town.	unknown State, Zip Code)
Z Z	od 2 s Ith an 27 is trau		Betty J. Helman	/daughter	1			lenton, Mar		
ē,	s 1 ar f Hea itam other		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of matory or other place		Date	•	City or Town, State
E	Page: ient o nt: If i		1 XBurial 2 ☐ Cremation 3 ☐ Re  1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State				lar 11, 08	Brookly	n Park, MD
Baltimore, Maryland	permit. Departrr Importa any inju		21. Signature of Puneral Service Licens	2/	22 D	2. Name and Addres	s of Facility Funer	al Home & Rd. Odento	Cremato	cy, P.A.
ŗ			23a. Part1. Enter the disease, or complice shock, or heart sallere. List only on	ations that caused the deat						Approximate Interval Between
	Pnysician	Ø 1	Immediate Cause Final disease or condition	2	VTIA					Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq						
	Examiner	L	Sequentially list conditions, if any, leading to immediate							
W	ed isi	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):					
1	xecut and al-trar	xan	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	ate be executed thysician and the burial-transit	cai E								
9	ificate g phy as the		<u> </u>							
Вох	law requires that the death certific. as been signed by the attending pl 2 should be detached for use as t	Physician/Med	23b. was decedent pregnant	3c. If yes, outcome of pregna 1□Live birth 2□Feta		∃Ectopic pregnancy				te of delivery
	ed for	sicia	in the past 12 months?	4☐ Pregnant at time of d		Other (specify)			Мо	nth Day Year
P. O.	res that the de igned by the a be detached f	Phy	9 Unknown					oge Bid	A-b	ribute to the cause of death?
	signer d be d	by	FAILURE 7	THAIL		nderlying cause give	en in Pan I.		Yes 3. No	3 ☐ Probably 4 ☐Unknown
Ö	w requir been si should	eted	FAILURE	- //////					~	
Records,	0 - 0	Completed						24a. Was	osy	Were autopsy findings available prior to completion of cause of death?
	ician: The l certificate ha rector, page	e Co	25. Was case referred to medical				00.01	1 Tyes		1 ☐ Yes 2 ☐ No
Vital	iding Physician: th. 1 After this certifica 1 funeral director, p	To Be	examiner?	ospital: 1 ☐ Inpatient 2 ☐	EB/Outpatier	nt 3 DOA Othe	25	of Death (Check only rsing Home 5 ☐ Res	173	SISTED LIVING or (Specify)
of	g Phy er this eral c		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o				how injury occur	
0	ttending death. ctor: Aft y the fun	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 1 ear)	injury		Yes 2 🗆 l	No		
Division	l or Attendate after death	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At his building, etc. (Specif	ome, farm, str	reet, factory, office			(Street and Numb wn, State)	er or Rural Route Number,
	rital o									
	To the Hospital or Attending within 24 hours after death.  To the Funaral Diractor: Afte completely filled in by the fune	edical	29a. Certifier 1 Certifying Phys (Check only one)  1 Certifying Phys 2 Medical Exemin	icien: To the best of my kno er: On the basis of examina and manner stated.	wledge, deat ition and/or in	h occurred at the tim vestigation, in my or	ne, date and pinion, deat	d place, and due to the th occurred at the time	cause(s) and ma date and place,	anner as stated. and due to the cause(s)
	o the	Me	29b. Signature and title of certifier			29c. License			29d. Date signe	d (Month, Day, Year)
	F>F0		I hornego mi			05	753		March	07,2008
	10		30. Name and address of person who con	npleted cause of death (Iter	п 23а) (Туре,	Print)				
	1		mobit Negr	Repleted cause of death (Iter  8 Col Va Taylor  32. Segistrar's Signal	ins Me	uy Inch	にんこ	y milla	rsville	mg 21:08
	Sta		31. Date filed (Month, Day, Year); MAR 1 3 20	32. Segistrar's Signa	ature	mark o				
	Registr	ar	METAL TO ZUI	The state of the state of	NOT ASS	ALC: SI				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 9 /Medical Eacility Name (If not institution, give street and number) 4b City, Town, or Location of Death Examiner 4c. County of Death N/A If Under 1 **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months 1 □ M 2 🙀 F Director No. Carolina 214-58-6338 56 Sep 29, 1951 Usual Residence of Decedent the Maryland 10b. County r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 MYes 2 No Directo N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be n 1725 Ramblewood Road 21239 U.S.A. Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ ★No Specify Completed by Specify. Black 3 ☐ Widowed 4 ☐ Pivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Good Samaritan Hospital Receptionist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Viola Rogers Henry Johnson ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8545 Okeefe Drive Severn, Maryland 21144 Antonio Bias Son 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Surial 2 □ Cremation 3 ☐Removal from State 4 Donation 5 DOther (Specify) Woodlawn Cemetery3/17/2008 | Williamston, N.C. 21. Signa are of Funeral Service 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Man 23a. Part1. Enter the disease, or complications that caused the deshock, wheart failure. List only one cause on each line. Approximate Interval Between Onset and Death in. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonary /Medical Due to (or as a consetuence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed burial-tran and Box 68760. Due to (or as a consequence of) physician Physician/Medical that the death certificate the the attending posterior as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9 Unknown cate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performe certificate 2 2 □ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ပ 1 Inpatient 2 PER/Outpatient 3 DOA After this 27. Mannet of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 ☐ Pending investigation 1 Natural (Month, Day Year) 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: 2 Accident the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D006008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen Devore Keeffe 5601 Loch Raven Blvd Balto, MD. 21239-2995 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar amend #1 Per Phy G877 3/13/08 In cate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ida Brandford Physician Day Month Year 11:30 a Mar 8, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Baltimore 1106 Sterrett Street 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 ☐ M 2 ⋤ F Director 215-30-9833 74 Dec 29, 1933 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notifled Director 1 Yes 2 No Maryland N/A **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō be permit. Pages 1 and 2 should be filed within 72 hours after death w Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Martin 1106 Sterrett Street 21230 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: 2 **X**No 1 ☐ Yes 2 ☐ No Specify: ģ Specify. 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Brandford Gertrude Brandford ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ricky Brandford Son 1106 Sterrett Street Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 DXBurial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 03/15/08 Brooklyn Park, Md. Cedar Hill Cemetery & Mausoleum 21. Signature of Funeral Service Lic 22. Name and Address of Facility Estep Brothers Funeral Service, 1300 Eutaw Place Baltimore, Md 21 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Ireast Guerotta /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transi The law requires that the death certificate be executer and Due to (or as a consequence of) physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) the detached 9☐Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy death? 1 ☐ Yes performed1 Yes 2 1No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only ope) examiner<sup>e</sup> Other: 4 Nursing Home 1 Yes 2 No P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 5 Residence 6 □Other (Specify) 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

P.O. Box 68760, Division or Vital Records, Physiclan: funeral director, After • Hospital or Attendi 24 hours after death. • Funeral Director; A death. the filled in by To the Hospital within 24 hours at To the Funeral D

Certification:

Medical

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

State Registrar

completely

29b. Signature and title of certifier

and manner stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ☐ Yes 2 ☐ No

31. Date filed (Month, Day, Year)

1 MAR 3 2008

5 Pending

investigation

6 Could not be determined

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1- State State Registrar amend #10e Per FH G8773/17/68 rifficate of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day March 8, 2008 Erika Pauline Brittain 1:45 Α 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Morningside House of Friendship Hanover Arundel Anne 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗹 Months Hours Director 212-28-8211 11/20/1919 Germany Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10h County 10d Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2 No Director MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hillside Road 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify ģ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Sales Associate Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Biewer Martha Karatiola 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: if Item 27 Is any injury or other trau Daughter 8349 Fairwood Court, Pasadena, MD 21122 Mary Hardesty / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State 03/12/08 | Glen Burnie, MD 4 □ Donation 5 □ Other (Specify) Glen Haven Mem Pk 22. Name and Address of Facility G.J. Gonce Funeral Home PA 21. Signature of Fugeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) wmonth **Physician** /Medical to (or as a consequence of) **Examiner** ertensive vascul Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of) Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause giver 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 TYes 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, a 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 2 No 1 🗌 Inpatient 1 Yes 2 ER/Outpatient 3 DOA ပ 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 21013 30. Name and address of person who completed cause of peath (Item 23a) (Type, Print) 24A Magothy Beach Rd Pasadena, MD Dailey, Loraine M. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ZUUY Month **Physician** Dorothy Viola Bapisteller /Medical 4c. County of Death City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Baltinose Ann Arusde County Daltimore Washington Med. Carter If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1□M 2MF 01/06/1928 214-24-1307 80 Marvland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland 10a. State Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director MD Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9207 Stone Spring Lane 21122 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10 College (1-4or 5+) Loan Officer Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Frenc Gertrude McKenna ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gerard Bapisteller/Son 9012 Giltinan Court, Springfield, VA 22153 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H
Important: If Ite
any Injury or of
once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 03/10/08 Cedar Hill Cem Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility G.J.Gonce Funeral Home, 21. Signature of Fineral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Obstructive Fulmonary Disease Immediate Cause (Final disease or condition resulting in death) **Physician** hvonu /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed? Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: ieral Director: After filled in by the funer 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 8 March 5, 2008 29b. Signature and title of certifier 30. Name and address of person who) completed cause of death (hem 23a) (Type, Print) Spital Drive, Gen Burnie, 10. 0

Registrar

State

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

20161

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year JAMES COX MARCH 03:30 A M 2009 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | OCT • 27, 1950 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 214 56 8631 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at MD 1X Yes 2 □ No N/A BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2745 MURA STREET 21213 IISA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, r than "natural", or items the Medical Examiner m 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No 2 Specify: 3 Widowed 4 Divorced USA Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry CORRECTIONS AT Elementary/Secondary (0-12) College (1-4or 5+) JESSUP vears COOK other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES ODELL COX. GLADYS DRUMMOND 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLADYS COX /MOTHER 2745 MURA STREET BALTIMORE, MD. 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State GREEN MOUNT CREMATORY 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTO, MD. 2) Signature of Funeral Service Licensee 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused me death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21213 1412 E. PRESTON ST. BALTO, MD. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** EXSANGUINATION 10 HOURS /Medical Due to (or as a consequence of): **Examiner** UPPER GASTROINTESTINAL BLEEDING DAY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-transi ESOPHAGEAL VARICES YEAR Due to (or as a consequence of): physician Physician/Medical ALCOHOL CIRRHOSIS YEARS the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 autopsy perform or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Manyer, MEDICAL DOCTOR MARCH 11,2008 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIEN NGUYEN, THE JOHNS HOPKINS HOSPITAL, GOO NORTH WOLFE STREET. BALTIMORE MARYLAND 21287 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar

MAR 1 3 2008

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

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2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 11, **Physician** Dona Levenia Connelly 2008<sup>ear</sup> 1:30 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 960 Fell Street #316 Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🖾 F 219-82-0651 Director 47 Feb. 16, 1960 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 1X Yes 2 □ No Director Maryland Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 960 Fell Street #316 21231 USA Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ lf Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Assistant Director of other than " College (1-4or 5+) 5+ Elementary/Secondary (0-12) Catholic Relief Services International Finance 7 Is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Charles Donald Connelly Levenia Creamer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 5956 Ivy League Drive; Catonsville, MD 21228 Nadine Rubin Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ott once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 3/14/2008 Catonsville, Maryland <sup>22.</sup> Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 2122 21. Signatur of Fundal Se M01290 MD 21228 23a. Part1. Enter the disease, or complications that caused the death. shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** ARUNOMA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and stransit Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760. Physician/Medical attending pt for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

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DHMH 17 Rev 1/2001

ORIGINAL

08-01911 Valerie Cooper Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	ner	Valerie B. C	Cooper						March 7,	2008	County of Do		041113
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		4750 Melbourne Road	d			Baltimore		- 01	0 Data of F	I I	N/A DD/YYYY) 9.	Righplace	(State or
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under Hours	Min.			Fo	reign	
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	ŀ	Usual Residence of Decedent										100	Inside City Limits
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or 28	Director	4750 Melbor	rne Road			21229				US	A		
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ORIGINAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1-For State Certificate of Death Registrar.	Reg.	. No. 20	08 0812
	Physici	an/	1. Decedent's Name (First, Middle,Last)  2. D	ate of Death	Day Year	3. Time of Death
Me L	dical Exami	ner	Mark Edward Carniewski  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	larch 6, 20	4c. County of Dea	1210 hrs
Y	1		104 Cross Keys Road Apartment F Baltimore			
	Funeral Director		183.54.1247 124 48 Yrs. Months Days Hours Min.		.1960	Birthplace (State or eign Country) PA
	any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	and show:	'n	MD N/A Baltimore			1 Yes 2 No
N	Maryla 28a-f dato	rect	10e. Street and Number 10f. Zip Code		. Citizen of What C	ountry?
$\mathcal{O}$	ith the 23a or notifie	al Di	104 Cross Keys Road Unit F 21210		U.S.A.	erice Indian Block
/	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral Director	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes, specify Cuban, Mexican, Puerto Rica		White, etc	erican Indian, Black, White
1	10urs a 1atura Xamir	ed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work during most of working life. DO NOT use retired)	done 1	16b. Kind of Busines	s/Industry
	36 iin 72 h i: han "r dical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		Bankin	2
	21215-0036 buld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Com	12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First	st, Middle, Ma		
	1218 lbe fill ental H arked	Be	Edward Carniewski Doris Mc			
	D 2 should and Mt 7 is ma	٢	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural  19c. 10/ Con 25 IV 200 Del			21210 1
	e, M and 2 Health item 2		Mark Carniewski/Self 104 Cross Keys Rd.  20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Da	te I	P BAIL 20c. Location - City	or Town, State
	nor Pages 1 ent of 1 nt: If		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: crematory or other place) Chesapeake Crem. 03.1	1.08	Beltsvi	lle. MD
	Baltimore, MD sermit. Pages 1 and 2 sho Department of Health and Important: If item 27 is nijury or other traumat		21. Signature of Funeral Service Licensee 22. Name and Address of Facility CAFA	/Step	hen D.	Lohrmann,
		_	23a. Part ). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or res			Balto.MD Approximate Interval
	Physician /Medical		failure. List only one cause on each line.			Between Onset and Death
1	xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Calibined Drug (Nor nine, Ux/codone, Trazodone) In Due to (or as a consequence of):	LOXICAL	TOIL	
		<u>.</u>	Sequentially list conditions, if any, leading to immediate			
		Examiner	cause Enter Underlying Cause			
1	d ansit		(Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):			
	760, icate be executed physician and the burial - transit	Medical	$\square$ unpended $\square$ amended 23a, part II, 27, 28a-f per ME g877, 3/14	/08 amh		
	760, icate be physici the buri	/Me	IF FEMALE:  23c. If yes, outcome of pregnancy  23b. Was decedent pregnant in the		23d. Date of deliv	· ·
	x 68 h certif ending use as	'sician/	past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)		Month	Day Year
	Bo) e deatl the att	Physi	1 Yes 2 No 9 Unknown 9 Unknown			
	5.0. that th	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Cardiomegaly			to the cause of death?  robably 4  Unknown
	ds, I	ted	Caldidiegaly	24a. Was ar	24b. Were	autopsy findings available
	COF e law r e has b e 2 sho	Completed		autopsy	ned? death	
	I Re n: The rtificate or, pag	ပ္ပ	25. Was case referred to medical 26.Place of Death (Check only	1 Yes 2	No 1 <b></b>	Yes 2 No
	Vita hysicia this ce	To B.	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other 4 Nursing Ho	ome 5 R	tesidence 6 🗸 O	her: Scene
	Division of Vital Records, P.O. Box 687 tal or Attending Physician: The law requires that the death certific its after death.  **I Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as the content of the conten		1 Natural (Month, Day, Year)	d. Describe ho	ow injury occurred	
	ivision  Tor Attend after death Director:	catio	Accident Investination Found 03/06/08 Found 11:40 artificial lines 1 a	known	reet and Number or	Rural Route Number City
	Divi	Certification:	3   Suicide   6   X Could not be   25e. Place of Highly Found Residence   Specify) Found Residence   Bai	or Town, Sta 1timore.	mb 21209	Rural Route Number, City Keys Rd, Apt. F
	Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due	to the cause	(s) and manner as s	
	To the within To the	ledical	one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.			
و ا		Σ	29b. Signature and title of certifier  29c. License number  O.C.M.E.		29d. Date signed (March 7, 2008	
	L I		30. Name and address of person who completed cause of death (Item 23a)		<u> </u>	
	30 perd		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			
	S Regis	tate	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			
-	regis	11:11	MITAL AND AND AND AND AND AND AND AND AND AND			

			For State Registrar	State of Ma	ıryland	-	artment of H		Mental Hy	giene Reg. No. 2	008	0.8	128
	Physic /Medi		1. Decedent's Name (First, Middle JAC				CHAIT		2. Date of De	_	2008°	3. Time of 6:25	P M
	Examir		4a. Facility Name (If not institution CHERRYWOOD NUR				4b. City, Town, or REIS	Location of Dea		4c. Co	unty of Death	E	
	Funeral Director		5. Social Security Number 213-09-8639	6. Sex 1 X M 2 ☐ F 9	(In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th 1.914	9. Birthp Cour	olace (State o	r Foreign
	show show	ŗ	Usual Residence of Decedent  10a. State 10b. County  MD BALT	IMORE		Town or Lo	eation EISTERSTO	J.IN			1	10d. Inside Ci	
uit	with the Maryland sa or 28a-f show t be notified at	Director	10e. Street and Number 12020 REISTER			ie K	10f. Zip Code	21136			of What Cour		
M 98	ges 1 and 2 should be filed within 72 hours after death with the Marylar to f Health and Mental Hygene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Marr. 3 □ Widowed 4 □ Divorced	12. Was Decedent E		11	∬ Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🗖 No		Specify Yes or No rto Rican, etc.)	)- 14.	Race - Americ Black, White, ecify: WH	etc.	
Maryland 21215-0036	within 72 hou ene. than "natura the Medical E.	Completed	15. Decedent	(Specify only highest grade completed)			Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PRORPRIETOR				of Business/Ind	dustry	
land 2	12 should be filed within "h and Mental Hygiene." I's marked other than "rtraumatic event, the Mec	To Be Co	17. Father's Name (First, Middle, SAMUEL	,	AIT			18. Mother's Na	ame (First, Middle			ER	
, Mary	and 2 shou alth and M 27 Is mai		19a. Informant's Name/Relationsl	hip (Type. Print) GILLIS /DA	AUGHT		ng Address (Street of				own, State, Zip 21048	,	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important; If Item 27 Is any Injury or other tra		20a. Method of Disposition 1	pecify)	20b. Pla	ZECHA	esition (Name of matory or other place IM CONG.		Date 12/2008	BALT	ion - City or To	MD	
Balt	permit Depart Import any In		21. Signature of Funeral Service	Pruger	_		2. Name and Address	TERSTOW		PIKES		MD 21	
8760, <	cate be executed by Sician and by Sician and the burial-transit the burial-transit categories.	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a c. Due to (or as a c. Due to (or as a c.	a conseque	ence of):	anhyte	lmy	avon respiratory a			Approximatinterval Batinterval	ween Death
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ital Re	sician: The law certificate has t irector, page 2 s	Be Com	25. Was case referred to medical					26. Place of De	auto perfu 1 Yes	ormed? 2 No	death?	ompletion of c	ause of
Division or Vital Records,	ng Phy ter this neral d	은	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	Hospital: 1 Inpatie	y 2	R/Outpatier 28b. Time o Injury	Worl	444 Nursing	Home 5 Resi			fy)	
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	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	edical	29a. Certifier 1 ☐ Certifyin (Check only one)	g Physician: To the best of Examiner: On the basis of and manner sta	examination	ledge, deat on and/or in	vestigation, in my o	pinion, death oo	ce, and due to the curred at the time	cause(s) an , date and pla	d manner as s ace, and due t	tated. o the cause(s	s)
	To To	Z	29b. Signature and title of contifier	/ Mo	, /		29c. License	1	7		igned (Month,		
	le		1 6	who completed cause of de	Alto	tten	Print)	1838 (	Treene	Tu	ae /	Ed t	# 300
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death **Physician** Narch enda 2008 /Medical acility Name (If not institution, give street and number) Examiner Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** MB 60 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Pres 2 No Baltimore MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21217 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Univer Md. Hospital Elementary/Secondary (0-12) College (1-4or 5+) ourdinator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Daughter) Solio 3 ira. Bulto. MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Baltimore, MD. 3-13-08 4 □ Donation 5 □ Other (Specify) areenmount 21. Signature of Funeral Service Licenses 22. Name and Address of Eacility Pure Funeral Services Vaughn & Greene Funeral Services 5154 Bultimor Nat'l Pike Bulto MD 21229 Vaugh 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last executed burial-transit and ied by the attending physician detached for use as the buria P.O. Box 68760, pe Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t d be detach 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2⊠ No 1 ☐ Yes 1 🔝 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physi within 24 hours after death. To the Funeral Director: After this of completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number HOPFUNH NACEM MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) phin Street, Baltimore, MD EM 501 32. Matrar's Signature AMATUN N NAEEM 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

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2008

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene? [] [] [ Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 27, 2008 **Physician** February 1:36 PM M Sandra Jean Dudek /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Columbia 6037 Camelback Lane 9. Birthplace (State or Foreign Country) New York If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 20, 1938 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 ☐ M 2 🂢 F Yrs. 113-30-1979 69 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2√ No Columbia Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21045 USA 6037 Cambelback Lane 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: white ģ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done du life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth any july or other traumatic event 2008. unk Lavinia Ann Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6037 Camelback Lane Columbia, MD Raymond J. Dudek/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Staff 4 X Donation 5 Other (Specify) 21. Simular of Euneral Service Lice State and Address of Facility ard 655 W. Baltimore Street m 21201 Baltimore, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myelogenous Leukemia Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) signed by the attending physicien and d be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 2 -No 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation s after dea. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide Hospital or To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 1 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H45931

State Registrar

MAR 13 2008

31. Date filed (Month, Day, Year)



Baltimore, MD Z1209

Baltimore, Maryland 21215-0036

Box 68760.

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Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-01918 State of Maryland / Department of Health and Mental Hygiene 2008 Theresa Ann DeRuggiero Certificate of Death 1- For State Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month 0056 hrs March 8, 2008 Medical Examiner Ann DeRuggiero Teresa c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** 720 Bosley Avenue - Penitentiary Towson If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Davs Hours Min. Country) MD Director 04.16.1964 213.94.9677 2 XF 43 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Yes 2 No Dunda1k Baltimore or 28a-f show Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21222 100 Rogers Cockrell Lane 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, by Funeral 12. Was Decedent Ever in U.S. White, etc. White 11 Marital Status the Medical Examiner must be Armed Forces? 1 Never Married 2 Married Yes 1 Yes 2 No specify: Specify: 4 Divorced If Yes, Give Year Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Departnet of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Ex. minez. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Home Maker 11 18.Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Phvllis Brown Be Wade Wheeler 19a. Informant's Name/Relationship (Type, Print ) husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 222 100 Rogers Cockrell La Stephen DeRuggiero Dundalk 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition

1 Burial 2 Cremation 3 crematory or other place) Removal from State 1 Burial 03.13.08 Beltsville, MD Chesapeake Crem. Donation 5 Other Specify: 22. Name and Address of Facility CAFA/Stephen D. Lormann 21. Signature of Funeral Service Licenses 101442 8717 Green Pastures Dr. Balto., MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Cardiac arrythmia Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): focal myocardial fibrosis and electrolyte imbalance complicating Sequentially list conditions Due to (or as a consequence of): morbid obesity if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last attending physician and or use as the burial - transi Physician/Medical # 1 per X UNPENDED The law requires that the death certificate be Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the Month Day 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 X No 9 V Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. 1 Yes 2 ✓ No 3 Probably 4 Unknown ρ Bipolar disorder Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? 2 No 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical or Attending Physician: of Vital Be Hospital: 1 Inpatient 2 Other, Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 this 2 No 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year After 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural 5 Yes 2 No Pending death. Director: Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be 3 Suicide determined Homicide 29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29bh Signature and title of certifier March 8, 2008 O.C.M.E. Whome 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

Margarita Korell MD.

3 2008

31. Date filed (Month, Day Year)

Assistant Medical Examiner

32. Resstrar's Signature

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Marci	10	Filis

Marcus Ellis		State of Maryland / Department of Health and Mental Hygiene  1- For State Certificate of Death Reg. No. 2008	3
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle, Last)  Agree Dond Van Ells  2. Date of Death Month Day March 6, 2008  3. Time of Death 0152 hrs	
Medical Examin		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	$\dashv$
_		7409 Liberty Road Windsor Mill Baltimore County	4
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD	
any	F	Usual Residence of Decedent  10a. State	s
<b>*</b> .	ō	MD Baltimore Baltimore 1 Tyes 2 XN	.0
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number  2420 Barnesley Place  10f. Zip Code  10g. Citizen of What Country?  USA	
with the ms 23a be noti		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,	ᅱ
er death	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year  1 Yes 2 No specify: Specify: Specify:	
ours aft ntural"	a P	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done  16b. Kind of Business/Industry	-
36 in 72 ho nan "nz lical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)  Research	
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D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be	Carl ton Ellis  Bridgett Scott  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number r Rural Route Number, City or Town, State, Zip Code)	
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nore, ME ages 1 and 2 s nt of Health a nt: If iten 27		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery,)  Date  20c. Location. City or Town, State  WOOTFAWN <sup>th</sup> WOOTFAWN <sup>th</sup> WOOTFAWN <sup>th</sup> And And And And And And And And And And	١
Baltimore, permit. Pages 1 at Department of He. Important: If ite		4 Donation 5 Other Specify: Work Manual Removal from State Work And Manual Removal from State Remo	
Baltii permit. Departm Importa injury o		Ulluarur U. Miller 18728 Liberty Koad Kandarstown MD 21133	
Physician 'Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Death  Death	
kaminer		Immediate Cause (Final disease or condition resulting in death)  a. Stab Wound of Chest  Due to (or as a consequence of):	$\neg$
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Box 68760, re death certificate be the attending physic reference for use as the burned		23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 5 Other (Specify)  Month Day Year	
Box e death the atte	hysic	1 Yes 2 No 9 Unknown g Unknown	
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rds, require been si	ompleted	24a. Was an 24b. Were autopsy findings availal autopsy prior to completion of cause of autopsy prior to cause of autopsy prior	
Reco	E G	performed? death? 1 ✔ Yes 2 No 1 ✔ Yes 2 No	
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ion of tending Planth.  or: After the funera	tion	1 Natural 5 Pending FOUND: FOUND: 1 Yes 2 No Subject stabbed	
Division of Vital Records, P.O. pital or Attending Physician: The law requires that it ours after death. neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	ertification:	28. Place of Injury - At home, farm, street, factory, office building, etc.  3 Suicide 6 Could not be determined determined (Specific) Companying a State (S	ity
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	O	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
To th within To th comp	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
		Donna Winch March 6, 2008	
2		30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
V St	at <b>e</b>	31. Date filed (Month Day Year) 2000 32. Revistrar's Signature	
Regist		1997/32 1 3 713170 MOVEMBER 1 201 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🦾 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARCH Year **Physician** ERRY 3:20 PM 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Battimore HOSPITAL NOVITHWEST MANDALLSTOWN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F 87 June 4, 165-12-2362 1920 Pennsylvania Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County MD Baltimore 1√2 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3213 Dorchester Road 21215 Funeral IJSA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2 💢 No Specify: Specify: black δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) handyman home repairs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jerry John Fisher Mary Delphine Roberts 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3213 Dorchester Road Baltimore, MD Eliza Lindey/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signatur Lun ra Service en wade State Anatomy Board 655 W. Baltimore Street ector 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate cause (Final disease or condition resulting in death)

a. SEPS (S Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): TRACT INFECTION Examiner UniNARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) the attending physician Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown ò been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2♥ No 1☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ospital c. 24 hours after dec. \*\*neral Director: After \*\* in by the fu 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2008 MARCH MD

Registrar DHMH 17 Rev 1/2001

State

OLD

5401 82. Registrar's Signature MIRCEA

COURT ROAD

ROGOT

RANDALLSTOWN

MD 21133

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NORTHWEST HOSPITA

Year)

1 3 2008

31. Date filed (Month, Day,

	4	State of Maryland / De State  For State Registrar  State Of Maryland / De State Of Maryland	epartment of H Certificate of L		ental Hygiei Reg.	- Z H H 2	08134
		Negistrar      Decedent's Name (First, Middle, Last)			2. Date of Death	140.	3. Time of Death
Physicia		John Andrew Fox, Sr.				Day Year 2008	5:05 A <sup>M</sup>
/Medica Examine	2.5	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death		4c. County of Deal	
Examile		7810 Clark Road Trailer D3	.T	essup		Anne Ar	unde1
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birt	hplace (State or Foreign
Director		217-46-7783   1X M 2 G F   61	s. Months Days	nouis Will.	04-07-19	,	ryland
p _		Usual Residence of Decedent	- Lacation				40d Incido City Limito
arylar show	_	10a. State 10b. County 10c. City, Town of	or Location				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
Ba-f s	<u>ဗ</u> ္ဓ	MD Anne Arundel		sup		0	••
or 2	ב <u></u>	10e. Street and Number	10f. Zip Code		10g.	Citizen of What Co	ountry?
ath v	- Ja	7810 Clark Road Trailer D3	207		oift Van er No	United S	
er de item	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	an, Mexican, Puerto	Rican, etc.)	Black, Whit	
rs aft camil	by	If Yes, Give  3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 🔀 No	Specify:		Specify:	nite
thou sales	9	15 December Education 16a F	ecedent's Usual Occup	ation	16b	. Kind of Business	
in 72 in Aedic	Completed	(Specify only highest grade completed) ( Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done of the contract of the	during most of worki f)	ng		
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othe othe	Bec	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Maid	den Surname)	
ary identice A LA I S-DUSO should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	9	Thomas W. Fox, Sr.		Fra	ances M. '	Thompson	
s ma		19a. Informant's Name/Relationship (Type. Print) 19b. I	Mailing Address (Street	and Number or Rura	ıl Route Number, Ci	ity or Town, State, .	Zip Code)
DEJILITIOTE, INICITY JICILIA 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.			7 57th Ave				
of He		20a. Method of Disposition  1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State	Disposition (Name of crematory or other place		)ate 20d	. Location - City or	Town, State
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Dalumino permit. Pages Department of Important: If if any Injury or once.		21. Signet Ore of Funeral Service Licensee	22. Name and Address Donaldson	ss of Facility Funeral 1	Home & Cr	ematory	РΛ
0 89 E 8 8	111	Mua Mungers	1411 Anna	polis Road	<u>l Odenton</u>	<u>, Marylar</u>	nd 21113
		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dyin	ng, such as cardiac o	or respiratory arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	a DX	une	ence 12	lefasis	Onset and Death
/Medical		resulting in death)  Due to (or as a consequence of	):	3			2148
Examiner		Sequentially list conditions.	linsem	_9	_		0.10.
D	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  C.	):				24cs. 6 renters.
and Arrans	каш	causer (bisease or injury that initiated events resulting in death) Last  C	my q				· · · · · · · · · · · · · · · · · · ·
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ched the d	isi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown					
		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause giv	en in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
uires luires lid be	d by				1X Yes	2 □ No 3 □ P	robably 4 Unknown
	Completed				24a. Was an	24b. Were a	utopsy findings available
The law the has b	d L				autopsy performed 1 Yes 2 ▼	prior to death?	completion of cause of s 2 □ No
VITAL iclan: T certificat ector, pa		25. Was case referred to medical		26. Place of Death	1 Yes 2 M	(NO I LI TE	2 140
	o Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	patient 3 DOA Oth	er.	me 5 Residenc	e 6 □Other (Spe	ecify)
g Phys er this eral dir	<b>⊢</b>	27. Manner of Death 28a. Date of Injury 28b. Ti			28d. Describe how		
Attending r death. ector: After by the fune	atio	1 Natural 5 □ Pending (Month, Day Year) in 2 □ Accident investigation		Yes 2 □ No			
lor Attending after death.  Director: After tin by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)	m, street, factory, office		28f. Location (Stree City or Town, S	et and Number or Fi State)	lural Route Number,
rs after safter	Çe						
		29a. Certifier (Check only)  1★ Certifying Physician: To the best of my knowledge, 2   Medical Examiner: On the basis of examination and					
the h	Medical	one) and manner stated.	29c. Licens	oo numbor	204	. Date signed (Mon	oth Day Year)
or vor	_	29b. Signature and title of certifier	23c. Licens	14-136	290.	3-7	
4				(			
10		30. Name and address of person who completed cause of death (Item 23a) (1	ype, Print)	. 11	· ol. 1.	nG1.	BuniemD
		31. Date filed (Month, Day, Year) 32 Registrary Signature	16002.0	rain Hu	9 25261	UGIENT	JUN'S MIT
Stat Registra		MAR 1 3 2008	Goods		-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1 2<u>008</u> **Physician** Thomas Charles Folderauer 2:45 P М 11 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 ☐ F Yrs 93 Director 217-05-6248 Jan. 25 1915 MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notifled at 1 ☐ Yes 2 ☑ No Director Towson <u>Baltimore</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 Dunvale Rd. #207 21204 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married "natural", or 1 ☐ Yes 2 No Specify: Specify: White ð 3 X Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Automotive Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing n/a Foreman permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygis important: If item 27 is marked other any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Folderauer Anna Palatar 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Karen F. Ege/daughter 24 Ballybunion Ct., Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 3/14/08 Lakeview Memorial Park Svkesville, MD 21. Signature nrice Licensee 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. O W. Padonia Rd., Timonium, MD 21093 23a. Part1. Enter the disease, or complications that can shock, or heard failure. List only one cause on each sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause Final disease or condition resulting in death) **Physician** a sonan ecws /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-tran the death certificate be exec Due to (or as a consequence of) ed by the attending physician detached for use as the burial Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 □ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No 9□Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₹ page 2 should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performed? this certificate 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ⊠ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 🔲 Inpatient 2 2 ER/Outpatient 3 DOA s after death. 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

P.O. Box 68760, or Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Division

Saltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) HAR 13

ERNESTINE WRIGHT, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

DHMH 17 Rev 1/2001

2300 DULANEY VALLEY ROAD

ristrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10<sup>Day</sup> **Physician** MARCH 2008 7:53 KONSTANTIN FLEYTMAN Рм /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 7 SQUIRE COURT REISTERSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 04/15/1983 9. Birthplace (State or Foreign Country)
BELARUS 6. Sex 1 X M 2 ☐ F 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 24 214-37-0477 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No **Funeral Director** MD BALTIMORE REISTERSTOWN 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7 SQUIRE COURT 21136 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No WHITE Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) WAITER RESTAURANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be YURY FLEYTMAN **ANGHELIKA** FLEYTMAN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7 SQUIRE COURT, REISTERSTOWN, MD 21136 ANGHELIKA FLEYTMAN / MOTHER 20b. Place of Disposition (Name of cemetery crematory or other) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any Injury or BALTIMORE HEBREW 03/12/2008 REISTERSTOWN, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Asphyxia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Justo (or as a consequence of) Examiner burial-trar law requires that the death certificate be execu Due to (or as a consequence of): Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown ģ signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ★No page 2 s has autopsy performed? 1☐ Yes 20X No certificate Physician: 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one Be Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: the Hospital or Attending suicide by Hanging 1 Natural 5 ☐ Pending investigation March 10,2008 un known 1 ☐ Yes 2 X No death. 2 Accident d in by the 6 ☐ Could not be 3 Suicide 4 Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Home 28t. Location (Street and Number or Rural Route Number, City or Town, State) 7 Scurre (Number, Reisters ow, My determined To the Hospius.
within 24 hours after
To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year)

3

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year) 13

2008



pleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 1235M Пау Year Month EVELUN MARCH 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Northwest Hospital Center Randallstown Baltimore 8. Date of Birth Sept 18, 1934 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 □ M 2 T F 73 Maryland 212-34-2416 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2XINo Gwynn Oak Baltimore Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1323 Dorchester Avenue 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Telephone Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter M. Schroeder Evelyn Abbott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James K. Geary, Son 4422 Linden Avenue Halethorpe, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/17/08 Lorraine Park Woodlawn, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor 2MacNabbook Funeral Home P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEU MONEL Due to (or as a consequence of): Sequentially list conditions, Due to for as a consequence of: cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobe

25 PINATONY FASILIATE STATUS PEST TEACHEOSTONY

DIABETES MENTILLE CONCURRENT ATTENDED

1 Yes

1 Yes

24a. Was an autopsy

24a. Was an autopsy

25 PART ACINETO BACTER IN Spirture;

25 PART ACINETO BACTER IN Spirture;

26 PART ACINETO BACTER IN Spirture;

26 PART ACINETO BACTER IN Spirture;

26 PART ACINETO BACTER IN Spirture;

27 PART ACINETO BACTER IN Spirture;

28 PART ACINETO BACTER IN Spirture;

29 PART ACINETO BACTER IN Spirture;

20 PART ACINETO BACTER IN Spirture; 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No RIGHT HIP FRACTURE; CHRONIC OBSTRUCTIVE LING DISTANT YES 2/10/10 26. Place of Death (Check only one) Hospital: 1 Phopatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical Examiner

be executed

Box 68760;

P.0.

Division or Vital Records,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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23a

"natural", or items 23a

traumatic event, the Medical

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marked other

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permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traum

filed withir Hygiene.

Maryland 21215-0036

altimore.

Director

burial-transi physician the for use as as been signed by the a certificate has been funeral director, After this

Physician/Medical ģ Be Certification:

Hospital or Attending hours a er death. within 24 hours a er death To the Funeral Director

the

Registrar

25. Was case referred to medical examine?
1 ☐ res 2 ☐ No 27. Manner - eath 1 ural 5 Pending 2 Accident

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

3 Suicide 4 Homicide

29a. Certifier (Check only one) investigation

MAR 13 2008

28a. Date of Injury (Month, Day Year)

February 20 2000 White M 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ASSISTED LIVING FACE. I. The City or Town, State) 15 25 Rolling St. (Specify)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State) 15 25 Rolling St. (Specify)

Cut on Street and Number or Rural Route Number, City or Town, State) 15 25 Rolling St. (Specify)

ASSISTED LIVING FACE II. The Course of Street and Number or Rural Route Number, City or Town, State) 15 25 Rolling St. (Specify)

ASSISTED ROLLING FACE II. The Course of Street and Number or Rural Route Number, City or Town, State) 15 25 Rolling St. (Specify)

ASSISTED ROLLING FACE II. The Course of Street and Number or Rural Route Number, City or Town, State) 15 25 Rolling St. (Specify)

ASSISTED ROLLING FACE II. The Course of St. (Specify) Course of St. (Specify)

ASSISTED ROLLING FACE II. The Course of St. (Specify)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 No

fal

MARGAND

28d. Describe how injury occurred

29c. License number D19502

29d. Date signed (Month, Day, Year) MANCH 12, 2008

HOSPITALLEN EN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ORIHNDO B. CONANTA, MD

32. Registrar's Signature

MINES SE

MONTHWEST RANDALIS TONN,

Use Selection of December   100. Chy Town or Location			1 - State amend #8 per Registrar	State of Ma Ana Bd (	aryland 3877	1 / Depa 3 <b>/20/</b> 0	artmer 18 JH Tificat	t of H e of L	ealth a Death	and M	lental Hy	giene Reg. No.	0(	18	08	138
** Pacifity Name of or Institution goes stress and members**  **Baltimore***  **Baltimore***  **Baltimore***  **Baltimore**  *	Physicis	an	1. Decedent's Name (First, Middle, Last,								2. Date of De	aath Day	,	Year	3. Time	of Death
15 S. Ellamont Street   Saltimore   Salt											Februa	ry 27	, 20	800	9:00	AM M
Some Source purposes 6 Size of Section 19   10   10   10   10   10   10   10	Examin	er								of Death		4c. C	ounty o	f Death		
217-24-536   I   W 20 F   77	F	3			e (In vrs. la.	st hirthday)				24 Hrs.	8 Date of Bir	rth		0 Ridhn	laco /State	or Foreign
Use A Relations of December   100. County   100. Coly, Town or Casalann   100. Coly Town or Casalann   100. Color Town or Ca	Funeral Director		10											Mary	land	or i oreigi
District Cited of Despotson   1   Burial 2   Corentains   3   Benoval from State   200. Place of Despotsion (Name of complete)   20c. Location - City or Town, State   20c. Place of Despotsion (Name of complete)   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Place of Despotsion (Name of complete)   20c. Location - City or Town, State   2			Usual Residence of Decedent								June 2	<b>20,19</b> 3	W			
District Cited of Despotson   1   Burial 2   Corentains   3   Benoval from State   200. Place of Despotsion (Name of complete)   20c. Location - City or Town, State   20c. Place of Despotsion (Name of complete)   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Place of Despotsion (Name of complete)   20c. Location - City or Town, State   2	mp T	L.	10a. State 10b. County		10c. City,	Town or Lo	cation							1		•
District Cited of Despotson   1   Burial 2   Corentains   3   Benoval from State   200. Place of Despotsion (Name of complete)   20c. Location - City or Town, State   20c. Place of Despotsion (Name of complete)   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Place of Despotsion (Name of complete)   20c. Location - City or Town, State   2	-88-f	ecto			Ba1	timore									Λ	S 2   NO
District Cited of Despotson   1   Burial 2   Corentains   3   Benoval from State   200. Place of Despotsion (Name of complete)   20c. Location - City or Town, State   20c. Place of Despotsion (Name of complete)   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Place of Despotsion (Name of complete)   20c. Location - City or Town, State   2	200	ă		woot			10t. Zip		21220	i -				nat Coun	try?	
District Cited of Despotson   1   Burial 2   Corentains   3   Benoval from State   200. Place of Despotsion (Name of complete)   20c. Location - City or Town, State   20c. Place of Despotsion (Name of complete)   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Place of Despotsion (Name of complete)   20c. Location - City or Town, State   2	ns 23	erai			Ever in U.S.	13.1	Was Dece				acify Yes or No			- Americ	an Indian	
District Cited of Despotson   1   Burial 2   Corentains   3   Benoval from State   200. Place of Despotsion (Name of complete)   20c. Location - City or Town, State   20c. Place of Despotsion (Name of complete)   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Place of Despotsion (Name of complete)   20c. Location - City or Town, State   2	2 4	Fun		Armed Forces? 1 ☐ Yes 2 ☐		1					Rican, etc.)	1	Black	, White,	etc.	
District of Centry (against a constitute of the	Era	Ď	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:			I □ Yes	2 <b>⊠</b> No	Specify:			S	pecify:	bla	ck	
District of Certify and State  20	릙	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Deced	lent's Usu	al Decupa	ation <i>Jurina</i> mos	t of worki	na	16b. Kind	of Bus	iness/Ind	lustry	
District of Petrity (against procession of 1   Date   20   Date	a Me	m d	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. L	DO NOT u	se retired,	, -							
District of Certify and State  20	. H			0			Garme	et Wo		de Nome	/Finat Adiabala				0	
Date of Creating Agriculture of Date o	*	Be		les					_					,		
Date of Creating Agriculture of Date o	mati	ř	The state of the s			19b. Mailin	a Address	(Street a						tate Zio	Code)	
The past is a supplied of the past is a supplied by the supplied by the supp	rtra															
23. April   Erica the defease, or combinations states of each   Done to the the mode of type; and a scardae or respiratory arrest,   Approximate   Part   Done to (or as a consequence of):	othe				20b. Pla	ce of Dispo	sition (Na	ne of	2)		ate	20c. Loca	ition - C	ity or To	wn, State	
Aproximate mediate Label and selections of the death of the mode of dying, such as cardiac or respiratory arrest, immediate Label and place of condition and the course of acute on each see.    Approximate mediate Label and place of condition and the course of the mode of dying, such as cardiac or respiratory arrest, immediate Label and place of condition and the course of the mode of dying, such as cardiac or respiratory arrest, immediate Label and place of condition and the course of the course of the mode of dying, such as cardiac or respiratory arrest, immediate Label and place of condition and the course of	ry or			emoval from State	Cert	netery, crem	Talory or C	uler place	1							
Security   Security	ny inju		21. Signature of Funeral Service License Ronald S	Ade Dire	ctor	22	Namear	de Addaes	rattoili	ў Воа	ard 655	W. B	alt:	iore	Stre	et
Sequentially list conditions resulting in death   Last	• 4	-	pmn//	1 the												
FFEMALE   23b. Was decelent pregnant in the past 12 module?   1   1   1   1   1   1   1   1   1	iner	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a conseque	nce of):										
### Part  ### Continuous control to the cause of death  ### Continuous for the cause of death  for the cause (s) and manner as stated.  #### Continuous for the cause of death  for the cause for the cause for the cause for the cause for the cause for the cause for the cause for the cause for the cause for the cause for the cause for the cause for the cause for the cause for the cause for the cause for the cause for the death  for the cause for		hysician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal d	leath 3						23			*	Year
25. Was case referred to medical examiner?    1	<u> </u>	þ	Part II. Other significant conditions cor	350	ut not result	ing in the ur	iderlying c	ause give	n in Part I.							
25. Was case referred to medical examiner?  1   Yes   No   Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Home   5   Residence   6   Other (Specify)    27. Manner of Death   1   Natural   5   Pending investigation   3   Suicide   4   Homicide   4	OB V BO	mplet									auto	psy	pri	or to con	osy findings npletion of	s available cause of
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Prudated Solst Par Prusate State  31. Date filed (Month, Day, Year)  32. Registrar's Signatuse	or.	O	25. Was case referred to medical						OR Disease	of Dooth			1 [	Yes	2□ No	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Prudatus M 30 St. PAUPL BAVIMONE 21252  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	direct			ospital:	nt 2□EF	R/Outpatien	t 3□ D0	A Othe			*		Other	(Specifi	·)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Prince Att 5 M 30 St. PAN PU BANTMONE 21252  State 31. Date filed (Month, Day, Year) 32. Registrar's Signatuse	Tuneral		1 ☑Natural 5 ☐ Pending			8b. Time of	2	8c. Injury Work	at ?	2					/	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Prudatus M 30 St. PAL PL BAWTMORE 21252  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		Certific	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injubulding, etc	ury - At hom c. (Specify)	e, farm, stre	set, factory	r, office		2			Vumber	or Rura	Route Nur	m <i>ber,</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Prudated Solst Par Prusate State  31. Date filed (Month, Day, Year)  32. Registrar's Signatuse	letely fill	edicai	Check only 2 Medical Examin	<b>167:</b> On the basis of	examinatio	edge, death on and/or inv	occurred estigation	at the tim , in my op	e, date an inion, dea	d place, a	and due to the ed at the time,	cause(s) ar date and p	nd mani lace, an	ner as st id due to	ated. the cause	(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Or WHAMS M 36 ST PAW PW BAWTMONE 2275  State 31. Date filed (Month, Day, Year) 32. Registrar's Signatuse	com	Σ		_			290	. License	number			29d. Date	signed	(Month, I	Day, Year)	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature			I ENSO ATUS	MS			1	DUT	193	9		WARC	4 (	5,2	058	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature			30. Name and address of person who co	mpleted cause of de	eath (Item 2	3a) (Type, 1		BA	brin	onx	2 7	าภ				
egistrar MAR 1 3 2008 A Sance As	Stai	е		32. Registra	ar's Signatu	50 A	30/2 0	- Y ! \ !	V 1 -1	,,,,	<u> </u>	1/0				

State Registrar

31. Date filed (Month, Day, Year)



SENVETH GEH, MS 3G BALTIMORQ MD21201. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ichael Albert Gra	1.	State of Maryland / Department of Health and Mental F - For State Certificate of Death		eg. No.	200	8 0814	
Physician	_	egistrar  1. Decedent's Name (First, Middle,Last)	2. Date of Deat	h	Vaca	3. Time of Death	
Medical Examine		Michael Albert Grady	Month March 6, 2		Year	2020 hrs	
	4	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat 8003 Chestnut Ave. Parkville	th		County of Death altimore Cou	ntv	
Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr	rs. 8. Date of Bir		DD/YYYY) 9. Birti		
Director	- (	029.40.8321 1 F 56 Yrs. Months Days Hours Min			Foreig	nuntry) MA	
any	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits	
land f show	<u> </u>	MD Baltimore Parkville				1 Yes 2 No	
hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once.		10e. Street and Number  8003 Chestnut Avenue  10f. Zip Code  21234	1	U.S	zen of What Coun		
r death with or items 23	5 7	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (\$\frac{1}{2}\$ Married Amed Forces? If Yes, specify Cuban, Mexican, Puert	Specify Yes or No to Rican, etc.)	-	White, etc.	can Indian, Black,	
her dea		Widowed 4 Divorced If Yes, Give Year 2 No 1 Yes 2 No specify:			Specify:	hite	
hours after a satural" xamine	2 2 -	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		16b. k	(ind of Business/I	ndustry	
1215-0036 Id be filed within 72 hours a hental Hygiene. narked other than "natura event, the Medical Examina Po Completed h		Elementary/Secondary (0-12) College (1-4 or 5+)  2 Salesman			Sal	es	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	5		ne (First, Middle,	Maiden			
21215-003 uld be filed within Mental Hygiene, marked other the revent, the Med	a l	Joseph Andrew Grady Eliza	beth K	ing	Belder.	1	
2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2/	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of 8003 Chestnut Av					
e, M I and 2 Health item 2	ŀ	20a Method of Disposition 20b, Place of Disposition (Name of cemetery,	Date	20c.	Location - City or	Town, State	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than " or other traumatic event, the Medical		4 Donation 5 Other Specify:			eltsvil		
Baltimore, MD permit. Pages 1 and 2 shu Department of Health and Important: If item 27 is injury or other traumat		21. Signature of Funeral Service Licensee 22. Name and Address of Facility CA	FA/Ste	ohe	n D. Lo	hrmann,	
Physician	+	P.A. 8717 Gree 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac				Approximate Interval	
Medical		failure. List only one cause on each line.  Immediate Cause (Final disease					
⊤xaminer		or condition resulting in death)  Due to (or as a consequence of):					
		Sequentially list conditions, but figure 1. Due to (or as a consequence of):  cause. Enter Underlying Cause					
ed nsit	E all	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
60, tte be executed hysician and e burial - transit	-   29	X UNPENDED   X AMENDEP, 23a per ME g877 3/14/08 amh   23 Pt. I	I, per ME	g878	4/3/08 am	it.	
zate be	Med	IF FEMALE: 23c. If yes, outcome of pregnancy	-	23	d. Date of deliver		
certification of the second of	F FEMALE:   23b. Was decedent pregnant in the past 12 months?   1						
Box 68760, e death certificate be the attending physic ed for use as the burities of the street of t	EL	1 Yes 2 No 9 Unknown 9 Unknown	T				
that the death certificat the death certificat by the attending phetached for use as the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Clinical History of Post Traumatic Stress Disorder	23e. Did			the cause of death?	
duires sen sign	Completed by	Clinical history of fost frametic briess product	24a. Was		24b. Were a	utopsy findings available	
COTC	릵			ormed?	death?	completion of cause of	
I. The tificate or, pag	<u>ج</u> ا	25. Was case referred to medical 26.Place of Death (Chee	1 ✓ Yes	2 r	No 1 ✓ Y	es Z NO	
f Vita Physician or this cer	ğή	overminer?	rsing Home 5	Resid	ence 6 🗸 Othe	er: Scene	
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the and read of the Albert Line Special Control of the Albert Line Specia		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe	how in	jury occurred		
Sior Attend death ector: by the	ĕ   ä	Accident  Pending Investigation   1 Yes 2 No Investigation   28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location	(Street	and Number or R	ural Route Number, City	
Divis	Certification:	Suicide  4 Homicide  6 Could not be determined  (Specify)	or Town,				
	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a consecutive one) 2 V Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred	and due to the cau ed at the time, dat	use(s) a e and pl	nd manner as sta lace, and due to t	ited. he cause(s)	
To with To con	흵	and manner stated.  29b. Signature and title of certifier  29c. License number			. Date signed (Me		
AV		o.c.m.e.		Ма	arch 7, 2008		
IVA	l	30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201					
2 TOL PURP	fe	Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  31. Date filed (Month, Day, Year)  32. Registrar's Signature					
Registra		MAR 1 3 2008 Reserve A Aparter					
DHMH 17 Rev 1/200	01	ORIGINAL		001	400		

			Please Type or Print in Black Inc			
				artment of Health and Menta	al Hygiene	00111
			1 - State Registrar Cer	tificate of Death	Reg. No LUU	08141
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Ralph Douglas Holland		te of Death onth Day Year Nrch 9 200	3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death  Baltinare	4c. County of Dea	ıth
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 5.79 98-5794 17 M 2 F 4/ Yrs.	onth, Day, Year) C	thplace (State or Foreign ountry)	
	land ow tt		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	cation		10d. Inside City Limits
	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If flem 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ector	MD Baltimure Reister	stown	10-00	1 □Yes 2 No
	th with t	Funeral Director	11919 Tarragon Rd. Umf	10f. Zip Code 21136	10g. Citizen of What Co	)
	r dea	ner	11. Marital Status 12. Was Dependent Ever in U.S. 13. Warmed Forces?	Vas Decedent of Hispanic Origin? (Specify Yef Yes, specify Cuban, Mexican, Puerto Rican,	es or No- etc.) 14. Race - Amo	
5-0036	ours afte al', or if Examin	þ	1 Never Married 2 Married 1 Yes 2 No If les, Give 1 3 Widowed 4 Divorced Year or Dates:	I∐Yes 2.2 No Specify:	Specify:	Black
215-0	in 72 hc n "natul fedical	Completed	(Specify only highest grade completed) (Give Notes of the Complete of the Comp	lent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business	/Industry
212	filed within Hygiene. ther than "	Com		ordinator	Menta	UHalth
Maryland	ild be file fental Hy rked oth fic event	To Be (	Ralph D. Holland	18. Mother's Name (First,	, Middle, Maiden Surname)  Withers	702CV
ary	2 shou and M Is mar aumat	-		g Address (Street and Number or Rural Route	e Number, City or Town, State,	Zip Code) 21136
	and 2 ealth m 27 I		Sally Holland/wife 1191	9 Tarragon Rd. 1	Unit D Rept	return pes
Baltimore,	ges 1 t of H if Iter or oth		20a. Method of Disposition  20b. Place of Disposition  Burial 2 Cremation 3 Removal from State	A - 1 - 2/17/10	20c. Location - City or	r Town, State
ţ	t. Par rtmen rtant;		4 □ Donation 5 □ Other (Specify) National	Cemotary 01 1101	& Salisbury	, NC
Bal	permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other once.		21. Signature of Funeral Service Licensee	728 Liberty Rd.	Randalkin,	General Stu MDZU33
	100		23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or he at b liure. List only one cause on each line.			Approximate Interval Between
.8	Physician		Immediate Cause (Final disease or condition	1 1 1 7520 FG FG		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a conse juence of):	4		
	LXUIIIIICI	<u>.</u>	Se uentially list conditions, if any, leading to immediate b. Due to (ur as a consequence of):			8 years
Τ	nsit	ä	cause. Enter Underlying Cause (Disease or injury			1342915
V.	executed in and ial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
120	tte be iysicia ne bur	ical	d			
.89	ertifica ing ph e as th	Med	IF FEMALE:			
.O. Box	iaw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medic	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 4 □ Pregnant at time of death 5 □ 9 □ Unknown	23d. Date of de Month	23d. Date of delivery Month Day Year	
Э,	s that ned b e deta	by Pt	Part II. Other significant conditions contributing to death but not resulting in the un-	derlying cause given in Part I.	3e. Did tobacco use contribute t	to the cause of death?
ord	w require s been sig should b	ed b			1 □ Yes 🎾 No 3 🗆 F	Probably 4 Unknown
or Vital Records,	law re las be	Completed		24	autopsy prior to	autopsy findings available completion of cause of
<u>~</u>	yslclan: The law is certificate has b director, page 2 s	Con		10	perfórmed? death? □ Yes 22 No 1 □ Ye	N.
Vit?	sician certifi rector	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (Chec		
ō	> 0 0	٠ <u>.</u>	27. Magner of 'eath 28a. Date of Injury 28b. Time of	4 Nursing Home 5	☐ Residence 6 ☐ Other (Speed escribe how injury occurred	ecify)
ion	Attending Physician: r death. ector: After this certifica by the funeral director, I	tion	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
Division	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, stree building, etc. (Specify)		cation (Street and Number or F ty or Town, State)	Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Co	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death one)  1 Medical Examiner: On the basis of examination and/or invariant manner stated.	occurred at the time, date and place, and du vestigation, in my opinion, death occurred at t	e to the cause(s) and manner a he time, date and place, and du	as stated. ue to the cause(s)
<b>L</b>	To the within To the comp	M	29b. Signature and title of certifier	29c. License number  MD + 45300	29d. Date signed (Mon	nth, Day, Year)
	$O_f$		30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print\	torical	21204
	Sta	te	31. Date filed (Month, Day, Year) 32. Fegistrar's Signature	York Roud, STE/01	-, 1000) 02	10'
	Registr		31. Date filed (Month, Pay Year) MAR 13 2008 32. egistrar's Signature	renti		
DH	MH 17 Rev 1/2	001				

# 3-8-08 AT MIGGINS, RICHARD

			Please 7		nt in Black In			-	475 475 175 495	00110		
			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of I <i>rtificate of</i>			iene UUS eg. No.	08142		
			Decedent's Name (First, Middle, Last)     2. Date of Death					th	3. Time of Death			
Physic /Medi			PICHAPD CLAPK HIGGING					Month March	Day Year 8 2008	9:15 p M		
	Examir							4c. County of Deat	h			
			122 BOXTHORN RD.			ABINGD			HARFORD			
	Funeral					If Under 1 Year Months Days		Year) 9. Birt	hplace (State or Foreign untry)			
	Director		215-58-4869 Usual Residence of Decedent		55 Yrs.			JAN 2	1953 MA	RYLAND		
ING Z1Z150035  be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural; or items 23s or 28s-f show event, the Madical Exeminar must be notified at	land w		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits		
	ξ	MARYLAND HARFORD CO ABINGDON					1 □Yes 2XNo					
	Director	10e. Street and Number 10f. Zip Code 10g.				0g. Citizen of What Co	untry?					
	h with		122 BOXTHORN RD			2100	9		U.S.A.			
	deat	Funeral		12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of	Hispanic Origin? (Sp pan, Mexican, Puerto	pecify Yes or No-	14. Race - Ame Black, White			
9	or its	F	1 Never Married 2007 arried	12∰Yes 2 ☐ N If Yes, Give	10	1 ☐ Yes 21⁄2 No		o riioari, oto.)	Specify: BLA			
ğ	urai',	d by	3 Widowed 4 Divorced	Year or Dates:	71/74							
7	"nat	Completed	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of world	king	16b. Kind of Business/	Industry		
2	withii ene. than	ᇤ	Elementary/Secondary (0-12)	College (1-4or 5	i+)		,		CIVIL SER	CIVIL SERVICE		
2	filed w Hygier other ti		12th grade   17. Father's Name (First, Middle, Last)	2 yrs	TES	T DIRECT		ne (First, Middle, I		V101		
Men with	id be ental ked o	To Be	CHARLES HIGGINS				ELSIE H	TCCTNS				
	2 shou and M is mar eumat	ř	19a. Informant's Name/Relationship (Ty)	ре, Print)	19b. Maili	ng Address (Stree			; City or Town, State, 2	ity or Town, State, Zip Code)		
	and 2 eelth a n 27 ts		Carolyn Higgins/W	ife	122	Boxthor	n Rd Ih	inadon.	Maryland 2	1009		
Ψ	es 1 a of He of Hem f Item r othe		20a. Method of Disposition		20b. Place of Dispo		E 4 - 1 - 2 - 2		20c. Location - City or			
Ĕ	Pages nent of ant: if it ary or o		1 ØBurial 2 ☐ Cremation 3 ☐ R  1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ST. JAME	-	1	-08 F	EDERAL HIL	L, MARYLAND		
ä	permit. Pag Department Importent: i any injury o once.		21. Signur re of Funeral Service Ligense	e	22 W	2. Name and Addre	BROWN CO			RFORD, P.A.		
n	80 E 2 9		Durbaja Gol	run					ABERDEEN,			
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused e cause on each lir	the death. Do not ent ie.	er the mode of dyi	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death		
F	Physician		Immediate Cause (Final disease or condition	arter	e Sclerote	is care	Rio Vasor	las des	unu	Oriset and Death		
1	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):			•				
		5	Sequentially list conditions,									
/	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
	be executed sicien and burial-transit	Xal	that initiated events c									
	e be /sicie	=										
20	tificat ig phy as th	led										
פס	death certificate be attending physic d for use as the b	Physician/Medica	230. Was decedent pregnant	. Was decedent pregnant 23c. If yes, outcome of pregnancy						23d. Date of delivery		
D	ed fo	Sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at		Other (specify)			Month	Day Year		
Э	that the de ned by the s detached t	Phy	9 Unknown					00 - Bidde				
ecords, P. law requires that as been signed b	signe bed	δ	Part II. Other significant conditions con	induting to death bu	at not resulting in the u	nderlying cause gi	ven in Paπ I.	239. Did tot	pacco use contribute to es 2 □ No 3 \rightarrow Pr			
	requ	Completed	Dinver	$\nu_{i}$	- 0				Х			
He	The law ate has	m m	Heyer	liso	roler			24a. Was a autops perform	y prior to o	topsy findings available completion of cause of		
			25 144					1  Yes 2	No 1 Yes	2 No		
= :	certi	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	nt 2 ER/Outpatier	Ott	26. Place of Dear	th (Check only on		**		
Phy r this	ar this	-	27. Manner of Death	1 ☐ Inpatie	y 28b. Time of	IL SU DOA	4 🗆 Nutsing A		Residence 6 Other (Specify)			
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific: completely filled in by the funeral director,		atio	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28b. Time of Injury 4 Work?  1 Yes 2 No									
<u> </u>	ar deg	tifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ury - At home, farm, str	eet, factory, office				and Number or Rural Route Number,		
5 ;	s after or	Certification:	3 ☐ Suicide 4 ☐ Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street City or Town, Sta					r, State)				
	4 hour	edicai	(Check only 2 Medical Examin	ician: To the best of	of my knowledge, deatle examination and/or in	occurred at the ti	me, date and place,	and due to the cared at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)		
	the I	Med	one)	and manner sta	ted.	1 11						
	S = 2 S	-	29b. Signature and title of certifier	10 4		A ACA	111-01	25	9d. Date signed (Monti	, Day, 18a1)		
_	1.1		Imark J. y	wom M	1) DIME	JOO!	14206	P	Kuch 10, Ze	000		
E	11		30. Name and address of person who for	M MI I IM	eath (Item 23a) (Type,	HUM HUIT	KRA RI	EL AID	March 10, 26 Mad 2101	5		
	Sta	te	31. Date filed (Month, Day, Year)	32 Registra	r's Signature	and B	- 10 02	1114	" J. J. 10"			
	Registr	ar	MAR 1 3 200	O BORNE	15 Mg	0000						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Harold Howard Hopkins 10:38A /Medical March 2008 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Knollwood Manor Nursing Home Millersville Anne Arundel 8. Date of Birth (Month, Day, Year) if Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□F Director 86 223-24-8580 May 09, 1921 Virginia Usual Residence of Decedent a or 28a-f show the notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director MD Anne Arundel <u>Millersville</u> 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a 1772 Baldwin Drive Funeral 21108 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 2 Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Farmer 1 and 2 should be filed w Health and Mental Hygie Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Virgil A. Hopkins Catherine M. Sandaal 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 i <u>Margaret J. McNatt / Daughter</u> 1772 Baldwin Drive Millersville, Maryland 21108 permit. Pages 1 a
Department of Hes
Important; If Item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 03-10-2008 Odenton, Maryland un 1 Funeral Service Licen 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each like. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA Physician disease or condition resulting in death) WEEK /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed **₩** Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ABDOMYD SARCOMA OF 1 ☐ Yes 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of I Director: After to in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 X Natural
2 ☐ Accident 5 Pending investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours after To the ...

To the Funeral Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar

29b. Signature

C. WALLACE MD 31. Date filed (Month, Day, Year)

MAR 13

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9005 32 Degistrar's Signature

**ORIGINAL** 

29c. License number

D31136

29d. Date signed (Month, Day, Year)

KILBRIDE RO, BALTIMORE, MD 21236

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deatl Month **Physician** 6:19 P<sup>M</sup> Jacqueline Dell Heacock March 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 👿 Director 215-40-4006 67 Dec 21, 1940 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notifled at 1 ☐ Yes 2 No Director MD Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1241 Dicus Mill Road 21108 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "n
any injury or other traumori-Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward L. LeCompte Dell Koppold ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie D. Heacock /spouse 1241 Dicus Mill Road, Millersville, Maryland 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. Mar 11, 08 Glen Burnie, Maryland 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. 21. Signature of Funeral Service Lense M00773 1411 Annapolis Road, Odenton, Maryland 21113 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fillips. List only one cause on yetch line. Immediate Cau pring disease or conding n resulting in death) **Physician** TERLOSC lerotic /Medical oue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conseduence of Examiner requires that the death certificate be executed burial-transi Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed page certificate 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 this 28a. Date of Injury (Month, Day Year) funeral 27. Mainer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident within 24 hours arter ....
To the Funeral Director: Afr 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

31. Date filed (Month, Day, Registrar 2008

29b. Signature and title of certifier

Year)

29a. Certifier

Medical

egistrar's Signature

NES

and address of person who completed cause of death (Item 23a) (Type, Print)

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eouty

		1	State of Maryland / Department of Health a  1- For State Registrar  Certificate of Death		giene 008	08145		
			Decedent's Name (First, Middle, Last)	2. Date of De Month	ath Day Year	3. Time of Death		
	Physicia /Medic	560	Marian Jean Harper	March	06, 2008	19 40 by		
	Examin	Control of	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of	of Death	4c. County of Death			
		Mary State	Anne Arundel Medical Center Annapolis		Anne Arı			
	Funeral		5. Social Security Number  1 M 2 K F	Min. (Month, Da	h, Day, Year) Country)			
- P.	Director		173-36-5441 61.	03-18-	1946 FeIII	Sylvania		
	yland now		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
	a-f et	ctor	MD Anne Arundel Odenton			1 Yes 2 No		
	or 28	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co			
	ath w		1220 Hillcrest Road 21113	nin? (Specify Ves or N	United Sta			
	er de Items	nue	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2♥ Married  1 □ Yes 2▼ No	n, Puerto Rican, etc.)	Black, White			
36	Ir, or	by Funeral	1 Never Married 200 Married 1 Yes 2 0 No If Yes, Give Year or Dates:		Specify: W	hite		
21215-0036	filed within 72 hours after death with the Maryland Hyglene. ther then natural; or Itema 23a or 28a-f ehow int, the Mudical Examinat must be notified at	ted	15. Decedent's Education 16a. Decedent's Usual Occupation  (Give kind of work done during mos	t of working	16b. Kind of Business/	industry		
215	thin 7	pie	(Specify only highest grade completed)  (Specify only highest grade completed)  (Give kind of work done during most life. DO NOT use retired)		Maryland	Board		
	filed with Hygiene. other than	Completed	2 Secretary	er's Name (First, Middle	of Educa	tion		
Ind	tal H d off	Be	17. Father's Name (First, Middle, Last)					
3	should nd Men marke umatic	은	Frank E. Tarr  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number	irginia E. er or Rural Route Numb		(ip Code)		
Maryland	d 2 sho							
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan ariment of Health and Mental Hyglene. ortant: if Item 27 is marked other than "natural", or itema 23a or 28a-f show injury or other traumatic event, it a Mardical Examination mat be notified at injury or other traumatic event, it a Mardical Examination.		Robert L. Harper / Husband  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or			
no	Pages nent of ant: If It ary or o	1	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  W. Arundel Crematory	03-10-2008	Odenton,	Maryland		
Baltimore,	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Fune	br	-			
ä	Depa Impo any i		1411 Anna olis	Road Odeni	ton, Marylar	id 21113		
			23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.		arrest,	Approximate Interval Between Onset and Death		
	Physician	ę s	Immediate Cause (Final disease or condition (esuiting in death)	10R	//	month		
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			10		
	i de	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
	nsit /	in in	cause. Enter Underlying Cause (Disease or injury					
,	be executed icien and burial-transit	Examin	that initiated events c			(		
760,	y s	cal	d					
89	leath certificat attending phy I for use as th	Med	IF FEMALE:					
Вох	ath ce ttendi or use	Physician/Med	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of de Month	Day Year		
0	the a	ysic	In the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  1 ☐ Unknown					
Ф	The law requires that the death certifica ite has been signed by the attending phoage 2 should be detached for use as it			I. 23e. Did	tobacco use contribute to	the cause of death?		
rds	quires n sign ald be	d by	Cardionyopathy, Acute renal Ra	11 lure 10	Yes 2 No 3 P	robably 4 Unknown		
Records,	s been si	Completed		24a. Wa	s an 24b. Were a	utopsy findings available completion of cause of		
Re	The lav	mo			formed death?			
Vital		BeC	25. Was case referred to medical 26. Plac	e of Death (Check only	one)			
of V	S ∞ 5	2	1 Yes 2 No Hospital. 1 Inpatient 2 ER/Outpatient 3 DOA One. 4 N		sidence 6 Other (Spe	ocify)		
n o		in oi	27. Manner of Death 28a. ate of Injury 28b. Time of Injury Work?  Natural 5 Pending (Month, Day Year) Injury M 1 Yes 2		e how injury occurred			
Division	or Attendiater death.  Director: A	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	28f. Location	(Street and Number or F	ural Route Number,		
Div	after Direct	Certification:	4 Homicide determined building, etc. (Specify)	City or T	own, State)			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	<u>a</u>	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date a	and place, and due to the	e cause(s) and manner a	s stated.		
	he Hd in 24 he Fu pletel	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de and manner stated.					
	To To To	2	29b. Signature and title of certifier 29c. License number	117	29d. Date signed (Mon	1000		
	10		1 1 0 1 mas a 1 0 0 0 0 1 1 0 0 0 0 0 0 0 0 0 0 0 0	11 /	2/0/0	00 8		
	10		30. Name and address of person who completed cause of geath (Item 23a) (Type, Print)  2001 Medical Parkway Annapulls	MD 214	OI MONIC	a Sounz		
4	S S	ate	31. Date filed (Month, Day, Year) 37 Registrar's Signature	1 1/2/1				
1	Regist		##和/5 1 の 2000   MA					

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1 - For State Registrar	State of Maryla		rtificate of L			giene Reg. No. 2	08	0814		
Decedent's Name (First, Middle, La					Date of Dea     Month	ath Day	Year	3. Time of Death		
Josephine L. Her					March	6, 20	800	1225P		
4a. Facility Name (If not institution, given Shady Grove Adversary)		- 1	4b. City, Town, or	Rockvill	_		y of Death			
5. Social Security Number 6. S		s. last birthday)	) If Under 1 Year	8. Date of Birtl		tgome:				
	□M 2KJF 9'	* /	Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	Birth Day, Year) 31/1910  9. Birthplace (State or F Country) DC				
10a. State 10b. County	10c. C	City, Town or Lo	ocation			·	1	0d. Inside City Limit		
MD Montgo	mery	aither	sburg			1 ☐ Yes 2 M2 No				
10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	itry?		
333 Russell Ave.	#623		20877-	-		United States				
11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bla Specii	ce - Americ ick, White,	etc.		
3 ☑ Widowed 4 ☐ Divorced  15. Decedent's Ed (Specify only highest gradult)	Year or Dates:	16a. Dece	dent's Usual Occupa kind of work done d DO NOT use retired,	ition	ing	16b. Kind of B	MIII			
Elementary/Secondary (0-12)	Own H	ome								
17. Father's Name (First, Middle, Last) Andrew Bergeson	Maiden Surnai eid	me)								
19a. Informant's Name/Relationship (	Type. Print)	19b. Mailir	ng Address (Street a	Henriet			State Zin	Cada		
Linda Humphrey/Da	ughter		orn Point				, otato, zip	Code		
20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	20c. Location Beltsv		wn, State  Maryland							
21. Signature of Funeral Service Licensee  MU0382  22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910–  23a. Partl. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approxim										
										Immediate Cause (Final disease or condition
resulting in death)		_								
Sequentially list conditions										
Sequentially list conditions, fany, leading to immediate cause. Enter Underlying										
Cause (Disease or injury that initiated events resulting in death) Last	c. CASTRO Due to (or as a conse		STIMAL	GE						
	DEED \		TIPA	MBOS						
	d. DEET	LLIN	IAKU	COGIN	10					
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>		23d. Date of delivery Month Day Year					
Part II. Other significant conditions co	ontributing to death but not re	sulting in the ur	nderlying cause give	n in Part I.	23e. Did tol	pacco use conf	tribute to th	e cause of death?		
PLEURAL	EFFUS				1 🗆 Ye			ably 4 ☐Unknow		
ATRIAL F	-IBRILLA	TION	V		24a. Was a autops perform 1∐ Yes	ned?	Were autor prior to condeath?	osy findings availab apletion of cause of 2 \( \square\) No		
Was case referred to medical examiner?	Hospital			26. Place of Death	(Check only on	e)				
103 22 140		ER/Outpatien		4 LI Nursing Hor				)		
7. Manner of Death  1   Natural  2   Accident  Could path be		28b. Time of Injury	Work	at 2 es 2 □ No	28d. Describe ho	w injury occur	red			
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	iome, farm, stre	eet, factory, office	2	8f. Location (St. City or Town	reet and Numb n, State)	er or Rurai	Route Number,		
Pa. Certifier (Check only one)  1 ☑ Certifying Phy 2 ☐ Medical Exam	/sician: To the best of my kniiner: On the basis of examin and manner stated.	owledge, death ation and/or inv	n occurred at the time vestigation, in my op	e, date and place, a inion, death occurre	and due to the ca ed at the time, d	ause(s) and ma ate and place,	anner as sta and due to	ated. the cause(s)		
9b. Signature and title of certifier  0. Name and address of person who c	met M.	D	29c. License			9d. Date signe		Day, Year)		
0. Name and address of person who o	ompleted cause of death (Item	m 23a) (Type, F	Print) FISE	HATSIOI E MD	1 ME	HART	M.D.	1		
1. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	and I							
MAR 1 3 200										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registra

Raymond Ha	rrison F	lorton
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	State of Marylan	d / Departmer	nt of He	alth and Me	ntal Hygiene	

ymond Harriso		orton Sta	ate of Ma	ryland /	Depar	tment of ificate of	Health Death	and	Menta	l Hyg		g. <b>N</b> o.	20	08	08147
Discolation in the second		Registrar  1. Decedent's Name (First, Middle	e.Last)		Och	modito or					Date of Death	1	Year		of Death
Physicia edical Examii	111/4	Raymon			н.		ton			l l	Month March 8, 20				08 hrs
		4a. Facility Name (if not institutio	n, give street a	nd number)		4	b. City, Tov Owings		cation of D	eath		1	ounty of Deal		
		230 Cedarmere Circle			. (1 10	et histhday)	If Under		If Under 2	4Hrs. 18	B. Date of Birth			_	(State or Foreign
Funeral	Ì	5. Social Security Number	6. Sex			st birthday)	Months	Days	Hours	Min.			C	ountry) 1ary1	
Director		217-56-7317	1 X M 2	JF	55	Yrs. Nov. 1					,			and	
à	ł	Usual Residence of Decedent  10a. State 10b. County			10c. City,	City, Town or Location									nside City Limits
how a		MD Bal	timore			Ow	Owings Mills						1 Yes 2 X No		
ie Maryland or 28a-f show any <u>fied at once.</u>	Director	10e. Street and Number					10f. Zip C	ode			10	g. Citizen	Citizen of What Country?		
the M a or 2		230 Cedarm	ere Cir	cle				211					USA . Race - Ame	orioon Inc	ion Black
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2 hour	ompleted	Elementary/Secondary (0-12)		lege (1-4 or		during m	ost of worki	ng life. [	OO NOT us	se retired	3)				
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	O	17. Father's Name (First, Middle	e, Last)					11				vialuen Su	irriame)		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Raymond Frank Horton Carol Clarke  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta										ate, Zip C	ode)			
MD 21 d 2 should ith and Mer n 27 is man	19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Rulai Route Name), etc. 4 19b. Mailing Address (Street and Number of Ru											21	117		
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altin nit. P partme portar 1ry or		21. Signature of Funeral Service	e Licensee			22.1	Name and A	Address	of Facility		824 R€				nd
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Division of Vital Records, ta or Attending Physician: The law requirer as after death.  Al Director: After this certificate has been simpled in by the funeral director, page 2 should be led in by the funeral director, page 2 should be	8	examiner?	cal Hospita	l: 4 lpps	atient 2	ER/Outpatie		26.Place	Other		g Home 5	Resider	nce 6 🗸	Other: Sce	ene
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ivisic lor Atter after dea Director	, <u>i</u>	2 Accident In	vestigation 2	8e. Place o	f Injury - At	home, farm, sti	reet, factory	, office	building, et	c.	28f. Location or Town		nd Number o	or Rural F	Route Number, City
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Division of Vital Records, P.O. Box 6876C the Hospital or Attending Physician: The law requires that the death certificate in 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physin the Funeral Director, page 2 should be detached for use as the b	1 5		Physician: To	the best o	f my knowle	edge, death occ	curred at the	e time, d v opinio	ate and plant ate and plant ate ath oc	ace, and curred a	due to the ca at the time, da	iuse(s) an te and pla	d manner as ice, and due	stated. to the ca	use(s)
Division of Vital Rec To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate Is completely filled in by the timeral director, page	Modical	one) 2 Medical E	an <u>a</u> r	nanner stat	ed.	and/or nivestly			se number				Date signed		
	2	29b. Signature and title of cer		10					M.E.			Mar	ch 9, 200	8	
		30. Name and address of pers	corule comple	ote Leaves	of death (Ite	em 23a)									
5.71	1	Laron Locke MD.	Assistant I				nn Stree	t, Balti	more, N	1D 212	201				
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Regi		BG 11 L	13 200	U 💉 🚳		15 M	The same								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 17 per fth 9877 3-13-08 vt. State of Maryland Department of Health and Mental Hygiene [] [] [] Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 03 Vear O8 **Physician** 09 10:40PM Johnson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Baltimore eistorstown 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 3. Date of Birth (Month, Day, Year) D8 D6 1916 7. Age (In yrs. last birthday) 6. Sex **Funeral** Min. 1 □ M 2 X F Months Days Hours NC 91 Yrs. Director .97 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show notified at Baltimore Windsor Mill 1 □Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be r USA Be Completed by Funeral 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) Black White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: Back 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Private Domestic 9th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental Nathaniel Johnson R<del>ebe</del>cca. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3126 Jeffrey Road Windor Mill, MD 2 nant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory, or other place) Date 20a. Method of Disposition Wilmington, NC 1 MBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Bethel United Church 03.15.08 Vaugun C. Greene Freneral sortices 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gleene MD 21133 8728 Liberty Road Randallstown 23a. Part1. Enter the Jisease, or complications that caused the death. Do not enter the mode of dying, shall as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementia **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit Due to (or as a consequence of): Physician/Medical use as t IF FEMALE: If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day cate has been signed by the atterpage 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 1 No 2 No 1∐ Yes or Attending Physician: the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital cal 1 🖵 CertifyIng Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(mD

2008

35. Registrar's Signature

E CONSTRUCT

Secry

31. Date filed (Month, Day, Year)

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Suite 200

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Records
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician PM masch 1:00 monie 08 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A SINAI HOSPITAL OF BALTIMORE Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) **Funeral** 1□M 2**1**F 29-56-74 7 Usual Residence of Decedent Director 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Inportant: If them 271s marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Blac Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Homema 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funcial Service Licerdee MOUYOL Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im to late Cause (Final disease or condition resulting in death) CARDIO MYOPATHY Physician 7 days /Medical Due to (or as a consequence of): Examiner ANOXIL BKAIN MM- GE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed To the Hospital or Attending Physician: The law requ within 24 hours atter death. To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Marrish RES - 000 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANISM TALWAR MOSPITAL OF BALTIMORE SINAI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

. Decedent's Name (First, Middle, Las	4					g. No. U U U		
14000/1/1/	EX VOHAIS	ON		i	2. Date of Death Month		3. Time of Death	
a. Facility Name (If not institution, give  KENS'/NGTON  Social Security Number  6. Second Security Number	Street and number)  NURSING EHATS 7. Age (In y	ENTE (?		r Location of Death  SING TO  If Under 24 Hrs.  Hours Min.		4c. County of Death		
Usual Residence of Decedent Oa. State 10b. County	10c.	City, Town or Lo					10d, Inside City Limits 1 ☐ Yes 2√ No	
	nue		10f. Zip Code	20895	10	0g. Citizen of What Country? USA		
1. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:			dispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, White	e, etc.	
15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of worki	ing	6b. Kind of Business/	Industry unk	
	0.54	40h Maili	unk	Evely:	n Donogh	ey Strong	To O to )	
	•						(ip Code)	
1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	b. Place of Dispo cemetery, crea	osition (Name of matory or other place	ce) [	Date 2	20c. Location - City or	Town, State	
		_				Baltimore	Street	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, f any, leading to immediate ause. Enter Underlying ause Coscess or many hat initiated events	a. Due to (or as a const	sequence of):		ng, such as cardiac d	or respiratory arre	st,	Approximate Interval Between Onset and Death	
	1 Live birth 2 F	etal death 3		,		23d. Date of del Month	ivery Day Year	
	*	-	nderlying cause giv	ren in Part I.			the cause of death?	
					autops:	prior to death?	utopsy findings available completion of cause of 2 No	
examiner? 1  Yes 2 No 27. Mann of Death 1  atural 5 Pending	28a. Date of Injury (Month, Day Year	28b. Time o	f 28c. Injur	er: 41 wursing Ho y at k?	me 5 🗌 Reside	nce 6 Other (Spe	cify)	
4 Homicide determined	building, etc. (Sp.	ecify)			City or Town	, State)		
29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Examone)	ysician: To the best of my iner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred at the til vestigation, in my o	me, date and place, ppinion, death occurr	and due to the ca ed at the time, da	iuse(s) and manner as ate and place, and due	stated. to the cause(s)	
29b. Signature and title of certifier	elo		00	9834		2/5/08	>	
	217-32-4917   15   2   2   2   3   3   3   3   3   3   3	217-32-4917   1	217-32-4917	1	Susal Residence of Decedent   D	Sustained   Decident   Substant   Dec Cuty		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 09, 2008 4c. County of Death March Corrine Jaeger 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Parkville Baltimore Oak Crest Village Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Social Security Number Days 1 M 2 F N.J 12.03.1933 74 150.24.7060 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 1 □Yes 2 No Baltimore Parkville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 Α. 8810 Walther Blvd. Apt. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No White 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) <u>Catherine Pauli</u>son George Varady 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 29 Palomino Trail Vernon, N.J. 0/462
Date 20c. Location - City or Town, State Tami Glander/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 03.10.08 Beltsville, MD Cheaspeake Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, 21. Signature of Funeral Service Licensee MOLYUB P.A. 8717 Green Pastures Dr.Balto., MD Ine Retter 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final etastatic breast cancer disease or condition resulting in death) Due to (or as a consequence of): Cliphastena Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner?

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

28a-f show

ral", or items 23a or 28a-f shov Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must tonce.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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Examiner

the

Physician/Medical 3

1 Yes 2 No

27. Manger of Death

1 Matural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

To the Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the

Division or Vital

Completed Be Certification: To

State Registrar

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

26. Place of Death Check onl one

Hospital: 1 ☐ Inpatient Other: 4 Aursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

determined

D61785 March

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dixon 31. Date filed (Month, Day, Year) MAR 13 2008 32. Registrar's Signature

Walther Blva, fartville, MD 21234

State of Maryland / Department of Health and Mental Hygiene U

08152 1 - For State Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** 18:39 <u>Helen Louise Jackson</u> 09 2008 0.3/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford de Grace Harford Memorial Hospital Havre Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral 1□M 2**≤**F Days Hours Months MD Director 212.58.6755 Usual Residence of Decedent 58 10.14.1949 10a. State 10c, City, Town or Location 10d. Inside City Limits or 28a-f show 10b. County 1 ☐ Yes 2 No by Funeral Director MD Harford Edgewood the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or iteme 23a or 2 runer roust be n U.S.A. 21040 1878 Grempler Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2 ☐ Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 250 No Specify: Black Specify: marked other than "natural", or matic event, the Wadical Exam 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 11 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If Item 27 ie marked other
any injury or other traument traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Black 2 Thomas Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1878 Grempler Way Edgewood, MD 21040 Charles Dea./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 03.13.08 Beltsville, MD Chesapeake Crem. 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, 21. Signature of Funeral Service Licenses du P.A. 8717 Green Pastures Drive, Balto.MD 23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
24 hours Immediate Cause (Final disease or condition resulting in death) Ischemic **Physician** /Medical Due to (or as a consequence of): Examiner Atherisc lerote Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Exami certensio Due to (er as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 4□Pregnant at time of death 5 Other (specify) s certificete has been signed l lirector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1X Yes 2 □ No Attending Physician: : After this certifice funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 700 1 Nepatient 2 1 ☐ Yes 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 De Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ŏ within 24 hours a To the Funeral D Medical 29a Carifier Scrittying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 1 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) gun 30. Name and address of person who mpleted cause of death (Item 23a) (Type, Print) 501 omora Union HVANUE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 3 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 I March 2008 **Physician** 11:08 A M Kees Walter Thomas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Greater Baltimore Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, May 3, 190 9. Birthplace (State or Foreign Country)

New Jersey 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1**X**M 2□ F 19Ó8 214-56-6860 99 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location item 27 ie marked other than "natural", or items 23a or 28a-f ehow other traumatic event, the Modical Examinal must be notified at 1 ☐ Yes 2 X No Director MD Harford Monkton 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 3018 Houcks Mill Road 21111 Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Yes 2 No Yes, Give 1 Never Married 2 Married land 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ Year or Dates: **WW** II 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5 + Elementary/Secondary (0-12) and Mental Hygiene. Physician Medicine 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hilton Goldie Kees Florence Warrington Blood 2 Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2. Department of Health a important: if item 27 ie any injury or other trau once. 3018 Houcks Mill Road Carol S. Kees, wife Monkton, Maryland 21111 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory, Inc. 03/12/08 4 □ Donation 5 □ Other (Specify) Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George MacNabb 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ntluenz Odays **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 Unknown s been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by Giant cell arteritis. steroid dependence 1 ☐ Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 2 X No 1□ Yes of Vital : After this certifice e funeral director, I Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; Division Injury 1 Natural 5 Pending To the Hospitel or Attendir within 24 hours efter death. To the Funerel Director: A' 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cauca(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 39a. Curtifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Lecceluw Gehartill M.D. D33400 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ehart III MD, 6301 N Charles St Boutinose, MD 21212 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1000 2008 3 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

Physiciar /Medica Examine

1 - For State Registrar

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Ex-miner must be notified at anone.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 3

	State Registrar			Cei	Certificate of Death						Reg. No. 2008 08 54					
	1. Decedent's Name (First, Middle, La	ast)						2. Date of D		Time W	***	3. Time of	Death			
an	Sang Sop Kim							Month March		2008	Year }	1:45	Δ M			
cal ier	4a. Facility Name (If not institution, gir	ve street and nu	mber)		4b. City, T	own, or Lo	ocation of Deat			4c. Count		1 1.43	Α			
101	Baltimore Washing	aton Med	Rical Co	ntor	Glen Burnie Anne Ar							3 - 7				
		Sex	7. Age (In yrs.								iace (State o	or Foreian				
	219-88-6029	XXM 2□F	84	Yrs.	Months	Days	Hours Min.	06-03			Coui	ntry) `	0			
	Usual Residence of Decedent				L			1 00-03		23	Sout	ch Kor	ea			
	10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	l 0d. Inside C	ity Limits			
ţ	MD Anne Ar	rundel		Se	evern				1 □ Yes				2 <b>N</b> O			
Be Completed by Funeral Director	10e. Street and Number				10f. Zip C	Code			10g. Citizen of What Country?							
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era	1251 Old Camp Me		edent Ever in U	S 13	Was Decede		1144 panic Origin? (S	necify Yes or N	0-		ed St					
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2	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi Year or D	ve		1 ☐ Yes 2 ☑ No Specify:					Specia						
훘	15. Decedent's E		dent's Usual	l Occupati	ion		16h	   Kind of F	<i>F</i> Business/In	Asian						
ete	(Specify only highest gr	k done dui	ring most of wo	rking	100	. Killa of L	JUSI 1633/111	dustry								
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ပိ	17. Father's Name (First, Middle, Las	<b>6)</b>		<u> </u>	rpente	Oenter Construct  18. Mother's Name (First, Middle, Maiden Surname)						on				
	, , ,	1)				'	O. MOUNEI S MAI	nother's Name (First, Middle, Maiden Surname)								
은	Sung Gu Kim			1	Sung Moon Bae  g Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (	(Street an	nd Number or Ri	ural Route Num	ber, Ci	ty or Town	, State, Zip	State, Zip Code)				
8	Jung Pak – daught	er					leade Rd	l., Seve								
	20a. Method of Disposition	Domount from	1 .	Place of Disponence of Place o	sition (Name matory or oth	e of her place)	)   Maa	Date	20c	. Location	- City or To	own, State				
	1 ABurial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Speci		Mea	dowrid	lae Mer	m. Pk		rch , 2008	E	lkrid	ge, M	ID				
1 5	21. Signature of Funeral Service Lice	nsee MOT	378		2. Name and			ary L. H					20 2+			
	aprini de		.0,0	72	50 Was	sh F		Elkrdige				al HOI	me at			
	23a. Part1. Enter the disease, or con	ijeations that	caused the deat								075	Approximat	te			
8 8	Shock, or heart failure. List only Immediate Cause (Final	one cause on e	each line.									Interval Bei Onset and	tween			
	disease or condition resulting in death)  a. Pretitionia  Due to (or as a consequence of):									1 wee	ek					
		Due to		,	_											
<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Duale			vascular Accident							5 yea	ers			
/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence or):							- 3					
am	that initiated events resulting in death) Last	C														
ũ	resulting in death) Last	Due to	(or as a conseq	uence of):												
ica		_d														
Jed	IE EEMALE.															
Z	IF FEMALE: 23b. Was decedent pregnant		tcome pf pregna birth 2  Feta		∃Ectopic pre	ananav				23d. Da	ate of deliv	ery				
icis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4∐Preg	nant at time of c		Other (spe					М	onth	Day	Year			
hys	9 ☐ Unknown	9□Unkn	own													
Completed by Physician	Part II. Other significant conditions	contributing to d	eath but not res	ulting in the u	nderlying cau	use given	in Part I.	23e. Did	tobacc	co use con	tribute to t	he cause of	death?			
d b								1	] Yes	2□ No	3 ☐ Prol	oably 4 🔀	Unknown			
ete								24a. Wa	o on	24h	Mora auto	nov findings	gueilable			
mpl			<u></u>					aut	s an opsy formeg		prior to co death?	psy findings mpletion of c	available ause of			
S								1□ Yes	20	No	1 ☐ Yes	2 X-No				
Be	25. Was case referred to medical examiner?	Lleonitel						ath (Check only	one)							
ဥ	1 ☐ Yes 2 ☐ No	- 25		ER/Outpatier			4 LI Nursing F	dome 5 ☐ Res	sidence	e 6 □Ot	her <i>(Speci</i> i	fy)				
ä	27. Manner of Death 1 Natural 5 Pending	28a. Date (Mor	of Injury hth, Day Year)	28b. Time o Injury	f 28	Bc. Injury a Work?	at	28d. Describe	how i	njury occu	rred					
atic	2 Accident investigation			М	1 ☐ Ye	es 2□No										
iţic	3 ☐ Suicide 6 ☐ Could not be determined	ome, farm, str	eet, factory,	office	lie	28f. Location	(Stree	t and Num	ber or Run	al Route Nun	nber,					
Ser		23110	ing, etc. (Specit	• •	City or Town, State)											
al (	29a. Certifier 1 Certifying P	hysician: To the	e best of my kno	wledge, deat	h occurred a	t the time	e, date and place	e, and due to th	e caus	e(s) and m	nanner as s	stated.				
Medical Certification:	(Check only 2 ☐ Medical Exa one)	miner: On the b	asis of examina ner stated.	tion and/or in	vestigation, i	in my opir	nion, death occ	urred at the time	e, date	and place	, and due t	o the cause(	s)			
Me	29b. Signature and title of certifier	_			29c.	License n	number		29d.	Date signe	ed (Month,	Day, Year)				
ASTO MAN NARGO									11	2000						

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) V MAR 13 2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death March 200°8 **Physician** S. Myoung Kwoun /Medical Anne Arund 4a. Facility Name (If not institution, give street and number) **Examiner** Glen Burnie Baltimore Woshington Medical Center 8. Date of Birth (Month, Day, NOV 30, 9. Birthplace Country) Korea **Funeral** 212-96-0354 Nov Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No ms 23a or 28a-f sh must be notified Director MD Anne Arundel Severn 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7601 Sharp Court 21144 Korea Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? "natural", or items 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify Completed by Specify: Korean 3 Nidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Principal Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ilsik Kwoun Ilho Kim 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Severn, Maryland 21144 Jin Kwoun (Son) 7601 Sharp Court 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park 3/14/08 Elkridge, MD 4 ☐ Donation ☐ Other (Specify) Cary L. Kaufman Funeral home at MMP, Inc. 7250 Washington Blvd. Elkridge, MD 21075 21. Signature of Funeral Ser M01290 s. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final theumonia **Physician** disease or condition resulting in death) /Medical Respirator Distress Syndrome Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine that initiated events resulting in death) Last The law requires that the death certificate be execu Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Dinpatient 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manuer of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) JAM MA March 12, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) USPITAL Drive, Glen Burne, MD. 301 HUSPITAL Drive, Glen Burne, MD.

DHMH 17 Rev 1/2001

State Registrar Jeorge

31. Date filed (Month, Day, Year)

WOUN,

**ORIGINAL** 

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 10:25aM March 07 2008 CECILIA J. KEITH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE If Under 1 Year N/A JOHNS HOPKINS BAYVIEW MEDICAL CENTER Year If Unde Days Hours Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 X Months 71 Yrs. SOUTH CAROLINA 10 1936 Director JUNE 212-32-5596 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at ₩XYes 2 □ No BALTIMORE N/AMARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 U.S.A. 4901 NELSON AVENUE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes = 2XXNo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXVo Specify: Specify: BLACK à 3XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) SOCIAL WORKER SOCIAL WORK 2yrs 12yrs permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other 1 any injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROSETTA HALL FRANK HALL SR. ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1716 N. Warrick Ave., Baltimore, Md 21216 Leonard Martin Jr./Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MARYLAND 03-15-08 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 21. Signature of Funeral Service Ligens 22. Name and Address of Facility WILLIAM C BROWN COMM FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocar dial **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, equentially list condition if any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed Due to (or as a consequence of) Box 68760, Physician/Medical The law requires that the death certificate 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Division or Vital Records, P.O. 9□Unknown 9 ☐ Unknown sate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a Was an autopsy performed? Ves 2 No certificate 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be ( 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 🗌 Yes After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) n 24 hours after de le Funeral Directo eletely filled in by ti determined 4 Homicide 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

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D0061907

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(hukwung F50. 1124 Mace Aveque Bultinore MD 21221

r's Signature 31. Date filed (Month, Day, Year) 32. Re MAR 13 2008

			State of Maryland / Department of 1- State Registrar Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate				eg. No.	008	08157
7	<b>D.</b>		Decedent's Name (First, Middle, Last)			Date of Deat     Month	h Day	Year	3. Time of Death
	Physicia /Medic	_	Charles B. Koetzle			March	11, 20	800	6:00 A. <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town	n, or Lo	ocation of Death		4c. Cour	nty of Death	
- A			Genesis Health Care  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday) If Under 1 Ye		Park If Under 24 Hrs.	8. Date of Birth		Aruno 9. Birthi	de1 place (State or Foreign
	Funeral Director		217-24-4475 1 M 2 F 77 Yrs. Months Day	ys	Hours Min.	(Month, Day, Oct. 2	Year)	Cou	ntry) yland
5.54	D		Usual Residence of Decedent			000.0	1750		
	arylan show d at	_	10a. State 10b. County 10c. City, Town or Location						10d. Inside City Limits 1 ☐ Yes 21 No
	he Ma 28a-f	ecto	Delaware Sussex Millsboro  10e. Street and Number 10f. Zip Cod			1	0a. Citizen o	of What Cou	
	a or 2	Funeral Director		 1996	66	'	USA	or withat oou	nay:
	ns 23	era	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent	cify Yes or No-	14. F	can Indian,			
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Department of Health and Mentall Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	Armed Forces? If Yes, specify €  1 □ Never Married 2 Narried   1 Nayes 2 □ No   1 □ Yes 2 1 Yes 2 □ No   1 □ Yes 2 1 Yes 2 1 □ Yes 2 □ Yes		Mexican, Puerto I	Rican, etc.)	Spe	lack, White,	hite
ב ה	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  Commercial Salesman  Commercial Salesman								idustry
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7	lled w Hygiel ther th		2 Commercial S		8. Mother's Name	(First, Middle, I			Company
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	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the M	2	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Str.	reet an	d Number or Rura	I Route Number	r, City or Tov	vn, State, Zi	p Code)
<u> </u>	1 and 2: Health a tem 27 is		Patricia J. Koetzle Wife 203 Serenade	e Co	ourt; Mi	llersvil	lle, M	aryla:	nd 21108
	es 1 a of Hei		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other	f place)	С		20c. Locatio		
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Dalillion	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Licensee  22. Name and Acr Funeral F  40/490  1630 Edm	nonc	dson Avei	nue: Cat	consvi	Schwal 11e. N	Mitzke MD 21228
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock or heart failure. List only one cause on each line.	dying,	such as cardiac o	or respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	1	four	lurs	2	i i	Oriset and Death
	/Medical Examiner		resulting in death)  Due to (or )s a consequence of):						
	13	-	Sequentially list conditions,  Due to (or se a consequence of):						
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5	the all	/sici	1  Yes 2  No	у)					
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cords	law req as beer 2 shou	Completed				24a. Was a		lb. Were au	topsy findings available
Ď L	The la	dmo				autop perfor 1∐ Yes	sy med? 2☐No	death?	completion of cause of
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>	y Physician: The law er this certificate has b eral director, page 2 sl	To B	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA	Other:	Nursing Ho	me 5 ☐ Resid	ence 6 🗆	Other (Spec	ify)
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VISION	Attending r death. ector: After by the funer	cati	2 Accident investigation M  3 Suicide 6 Could not be 28e, Place of injury - At home, farm, street, factory, of		es 2□No	28f Location /S	treet and No	imher or Ru	ural Route Number,
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	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	Medical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the desired of the property of the pasis of examination and/or investigation, in and manner stated.	he time my opi	e, date and place, inion, death occur	and due to the cred at the time,	cause(s) and date and pla	d manner as ce, and due	stated. to the cause(s)
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	681		30, Name and address of person who completed cause of death (Item 23a) (Type, Print)	1.	Mile	1	110	11:	121110
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Baby Boy Antho Ka
4a. Facility Name (If not institution, give street and number) 0930MM Z 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore City If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F **Director** none 2 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Baltimore Country 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be no once. 21237 USA 6227 Commons Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Antho Kalombo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hopkins Bayview Hospital 4940 Eastern Avenue Baltimore, MD 21224

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specity) nos 0; tal 21. Si mature of Euneral Service Lice 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C se (Final disease or condition resulting in death) Physician extreme /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any local grant of cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autop., performed: 2 No Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death. To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Medical the certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29b. Signature and title of certifier RESOOI

State Registrar

40 Eastern Avenue, Baltmore, Maryland

			For State Registrar		ite of Ma	aryland / I		rtment of H		Mental Hy	giene Reg. No.	800	08159
	Physici /Medic		1. Decedent's Name (First, Middle Rober	1	Kes	sha	ش			2. Date of De Month	Day	Vear Vear	3. Time of Death 3.24AM
)	Examir		4a. Facility Name (If not institution  Harbor		end number)	1			more		4c. Co	unty of Death	
	Funeral Director		5. Social Security Number 216–36–3413	6. Sex 1∏ M 2	□ E I	e (In yrs. last bii 68	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Aug 2,	th ay, Year) 1939	9. Birthp Coun	lace (State or Foreign try) unk
	aryland show dat	_	Usual Residence of Decedent  10a. State 10b. Count	ty		10c. City, Tow						1	0d. Inside City Limits
	Ba-f	cto	MD			Balt	imor	T					1 TYes 2 No
	th with the 23a or 2 ist be no	Funeral Director	10e. Street and Number 1345 E. Pataps	sco Ave	nue			10f. Zip Code	1225		•	of What Coun USA	itry?
730	urs after dea al", or Items xaminer mu	by Funer	11. Marital Status UI  1 Never Married 2 Ma 3 Widowed 4 Divorce	urried 1	as Decedent E ned Forces? ]Yes 2 ☐ N 'es, Give ar or Dates:			√as Decedent of His Yes, specify Cubar ☐ Yes 2[X] No	spanic Origin? (Sp n, Mexican, Puert Specify:	pecify Yes or No Rican, etc.)		Race - Americ Black, White, pecify: wh	
1212-0036	be filed within 72 hours after death with the Maryland tial Hyglene.  Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decede (Specify only high Elementary/Secondary (0-12) unk	Co	nleted) llege (1-4or 5		16a. Decedent's Usual Occupation (Give kind of work done during most of works life. DO NOT use retired)			<sub>king</sub> unk	16b. Kind	b. Kind of Business/Industry	
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nore, n	permit. Pages 1 and 2 Department of Health & Important: If item 27 Is any Injury or other tra		Harbor Hospita  20a. Method of Disposition  1	3 □Remova	al from State	20b. Place o	f Dispos	S. Hanove ition (Name of natory or other place	1	Baltin Date	20c. Locat	MD 212 ion - City or To	.25 wn, State
Башто	permit. F Departme Importar any Injur		21. Signature of Funeral Service Ronald			ector	St Ba	Name and Addres ate Anato ltimore,	s of Facility Dmy Board MD 2120	 1 655 W	. Bal	timore	Street
	Physician		23a. rt1. Enter the dise se, s k, or heart failu . Li.	complicati st only one caus	s hat caused se on each lin	the death. Do	not ente	r the mode of dying	g, such as cardiac	or respiratory a	irrest,		Approximate Interval Between Onset and Death
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,	rtificate be executed og physician and as the burial-transit	Examiner	Se juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):										. , , , , , , , , , , , , , , , , , , ,
x 00/00,	ertificate be ling physici e as the bu	Medical	IF FEMALE:	d							I.		
.O. DOX	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1		pt pregnancy 2 □ Fetal death time of death		Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day		
corus, r	quires that an signed build be deta	by	Part II. Other significant condi	tions contributi	ng to death bu	ut not resulting i	n the un	derlying cause give	n in Part I.				ne cause of death?
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	al or Attending Is after death. Il Director: After din by the funer	Certification:	3 Suicide 6 □ Could	d not be mined 28e	. Place of inju building, etc	iry - At home, fa c. (Specify)	arm, stre	et, factory, office	2   110	28f. Location ( City or To	Street and N wn, State)	lumber or Rura	l Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical C		al Examiner: O		examination ar		occurred at the time estigation, in my op					
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			30. Name and address of persons address of persons address o	on who complete	ed cause of de	eath (Item 23a)	(Type, F	Print) EDN	1699 A R. H	ELLIM	۵ ۱۰/۳	on,s	, 2008
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month March 9, 2008 8:40 AM M Adele L. Kerner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care Dulaney Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Jan 1, 1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Days 1 □ M 2 💢 F 90 217-07-8698 Jan 1, Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 □ No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1822 Landrake Road 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 housewife own home

**Physician** /Medical Examiner

Department of Health and Mental Hygienelin Important: If tiem 27 is marked other than any injury or other traumatic event, the Me once.

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

'natural', or items 23a or 28a-f show dical Examiner must be notified at

Director

Funeral

ş

Completed

MD

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

physician and is the burial-tran To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral

ă	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)							
2	Harold Herman Loc	ock		Pearl N	Matilda K	aiss				
	19a. Informant's Name/Relationship (7)	ype. Print)	19b. Mailing Address (Street	and Number or Rural I	Route Number, City	or Town, State,	Zip Code)			
	Albert Kerner/spou	ıse	1822 Landrak	rake Road Towson, MD 21204						
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specify	nemoval nom state	ace of Disposition (Name of emetery, crematory or other pla	ce) Dat	20c. l	ocation - City or	Town, State			
	21. Signature of Funeral Service Licens Ronald S	Wade, Hirector	ess of Facility Comy Board MD 21201	655 W. Ba	ltimore	Street				
	23a. Part1. Inter the diseas of comp shock, in heart failure. List only of Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death							
		Due to (or as a consequence of the CARD)	ence of):	THY			years.			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ence of):							
Cal Exc	resulting in death) Last	Due to (or as a consequent	ence of):							
Dalvi / IE	IF FEMALE: 23b. Was decedent pregnant	23d. Date of de								
l yalcı	in the past 12 mon#15? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		y		Month	nth Day Year			
בת ושא ר	Part II. Other significant conditions co	ontributing to death but not resul	lting in the underlying cause given	ven in Part I.			o the cause of death?			
on bier					24a. Was an autopsy performed?	death?	utopsy findings available completion of cause of			
2	25. Was case referred to medical examiner?			26. Place of Death (	Check only one)					
5	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3 □ DOA Oth	ner: 4 Nursing Home	e 5 ☐ Residence	6 □Other (Spe	ecify)			
anon:	27. Manner of Death  1 Patural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury M 1	ry at 28. rk? Yes 2 □ No	d. Describe how inj	ury occurred				
	3 ☐ Suicide 6 ☐ Could not be determined	and Number or R te)	ural Route Number,							
Calcal		rsician: To the best of my know iner: On the basis of examinati and manner stated.								
IAI	29b. Signature and title of confidence	ladino	29c. Licens	901284	9 =	ate signed (Mon 3-9-0	8			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  A.H. GHUADI, M.D. 7600 OSLER DI. Towson MD 21204									

State Registrar 31. Date filed (Month, Day, Year)

7600 32 Registrar's Signature

11:15A M

Birthplace (State or Foreign Country)

White

Month

Year

Day

MD

10d. Inside City Limits 1 ☐ Yes 2 ☐ No

DHMH 17 Rev 1/2001

Registrar

Benjamin

31. Date filed (Month, Day, Year)

5.

Leve

2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** Month March 8, Edward Jacob Lindauer, Jr. 7:10 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8256 Riverside Drive Pasadena Anne Arundel 8. Date of Birth (Month, Day, Year)
ADr. 19, 1 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 1 2 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 212-30-6613 75 Director 1932 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits MD Anne Arundel Pasadena 1 □Yes 2 No Director 10f. Zip Code 21122 10g. Citizen of What Country?
United States 10e. Street and Number 8256 Riverside Drive Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 XYes 2 □ No 195
If Yes, Give
Year or Dates: 195 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1952 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced 1954 Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 10 College (1-4or 5+) Supervisor Cemetery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Jacob Lindauer, Sr. Pearl Elizabeth Ozman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward J. Lindauer III - Son 212 Hillendale Avenue, Lansdowne, MD 21227 20b. Place of Disposition (Name of Lorriane Park Cemetery 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) 3-12-2008 Woodlawn, MD 22. Name and Address of FacilitAmbrose Fuenral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (Final NONIC **Physician** disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine the burial-transi and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death □Yes 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 VNo 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) ဥ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 Pending investigation Injury 1 Tyes 2 🗆 No death. 2 Accident Director; 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) o completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 13 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 12:20 PM M 2008 Maryenis Lindsay March 1, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Heritage Center Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☐ M 2 😿 F Director 84 27, 1923 240-18-9212 Aug Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natures" any injury or other traumatic exercises. 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7232 German Hill Road 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, unk 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: white Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation un 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7232 German Hill Road Dundalk, MD Genesis Heritage Center 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5\Other(Specify) in state 21 Signature of Funeral Service Ronald S State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD Aart1. Enter the disease, of compil ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart failure. List only one cause on each line, ediate Cause (Final asse or condition Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregpant in the past 12 months? 1 ☐ Yes 2 ☐ No 2 Fetal death 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by DISEASE 10 Yes 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autons performed? res 2 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 1 🗌 Yes <sup>2</sup> 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury thours after death. 1 ☐ Yes 2 ☐ No r death. 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature a

State Registrar 31. Date filed (Month, Day,

death (Item 23a) (Iypo Print) SY 10 — A

MARYLAN

				Please		int in Black In laryland / Depa			-	( ) ( ) ( )	08164
			1 - For State Registrar				rtificate of		, ,	eg. No.	00107
н	Physic	ian	Decedent's Nan	ne (First, Middle, La:	st)				Date of Death     Month	h Day Year	3. Time of Death
	/Medi			l Lambert					March	2, 2008	3:48 PM M
	Exami	ner	4a. Fecility Name	(If not institution, give	on, give street and number)  4b. City, Town, or Location of Death  4c. County of D						
				dgewood Ro		Edgewood Harfo					
ľ	Funeral Director		5. Social Security 041-34-6	5376	ex 7. A ▼ M 2□ F	ge (In yrs. last birthday) 62 Yrs.	Months Days		8. Date of Birth (Month, Day, July 3,	<sup>Year)</sup> 1945 Can	nthplace (State or Foreign ountry) Iada
	and *		Usual Residence of	10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryland 1 show	5	MD	Harfor	J						1 ☐ Yes 2√ No
8	A A A	ect	10e. Street and Nu	1	<u>u</u>	Edgew	10f. Zip Code		14/	0g. Citizen of What C	
80-2	23 With	Funeral Director		Edgewood 1	Road		Tot. Zip code	21040		Canad	,
C	B B C. B	ne	11. Marital Status		12. Was Deceden Armed Forces	t Ever in U.S. 13.	Was Decedent of H	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No-	14. Race - Am Black, Whi	
21215-0036	ral; or h	þ		rried 2 Married 4 XDivorced	1 万Yes 2 ☐ If Yes, Give Year or Dates:	No	1 ☐ Yes 2 <b>]</b> (7) No		rindari, oto.,	Specify: W	
5-0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.  Important: if itam 27 is marked other than "natural", of items 23a M 28b-1 show any injury or other traumatic event, if a Madical Examinar must be notified at angered.	etec	(Spe	15. Decedent's Ed	lucation de completed)	16a. Dece	dent's Usual Occup	pation during most of work	unk	16b. Kind of Business	Industry
7		npie	Elementary/Sec		College (1-4or	life.	DO NOT use retire	d)	ing .		
	ed w ygier nar th	Be Completed	unk		unk					constru	ction
Maryland	uld be fill fental H rked ott tic avan	To Be	17. Father's Name	(First, Middle, Last)			unk	18. Mother's Nam	e (First, Middle, N	Maiden Sumame)	unk
ary	should have		19a. Informant's N	Name/Relationship (	Type, Print)	19b. Maili	ng Address (Street	and Number or Rui	al Route Number,	City or Town, State,	Zip Code)
	alth a		Pastor T	homas Mur	nhv/clero	v 238 t	lictoria	Eoad hart	ford CT	06114	
Baltimore,	s 1 a f Hei itam othe		20a. Method of Dis	sposition		20b. Place of Dispo	sition (Name of natory or other pla		Date 2	20c. Location - City or	Town, State
9	Pages nent of } unt: ff its ury or of		1 Burial 2	Cremation 3 ☐ 5 🕅 Other (Specify	Removal from State	, ,	natory or other pla	(69)			
₫	artme ortar injur	1 %	Annual Contract		- 61		2. Name and Addre	ess of Facility			
Ba	Departiment Department		1 his	uneral Service icen	Made, Jir					Baltimore	Street
			23a Part1 Enter	the disease or come	plications that cause	d the death. Do not ent	altimore,	MD 2120	or recouration, arro	net .	Annrovimate
		4			one cause of each	d the death. Do not ent line.	2000				Approximate Interval Between Onset and Death
	Prysician	1	Immediate Cause disease or conditi- resulting in death)	on	aarten	soleratio	Cardie	vascular	dere	are.	
	/Medical Examiner	П	resulting in death)		Due to (or as	s a consequence of):					
	Examinici	_	Sequentially list co	onditions,	b						
	p ii	ine	Sequentially list of it any, leading to it cause. Enter Und Cause (Disease of that initiated event	erlying	Due to (or as	a consequence of).					
	be executed ician and burial-transit	Examiner	that initiated event resulting in death)	r injury is	c						
60,	be ex ician burial	ai E	1000king in county		Due to (or as	a consequence of):					
6876		lica			d.						
9	The law requires that the death certificate to the has been signed by the attending physic bage 2 should be detached for use as the bage 2.	Physician/Medic	IF FEMALE:								
Вох	th ce tendi	an/I	23b. Was deceder		23c. If yes, outcome		Ectopic pregnance	v		23d. Date of de	,
	it the death by the atte tached for	Sici	in the past 12	□No			Other (specify)	,		Month	Day Year
P.0	at the by the tach	hys	9 Unknowr	n	9 OHKHOWN						
	s tha	by P	Part II. Other signi	ificant conditions of	ontributing to death l	out not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	acco use contribute t	the cause of death?
ğ	quires t n signe uld be	b	1/0	me_					1 ☐ Ye:	s 2⊡No 3∭AP	robabiy 4 Dunknown
Records,	w requir been si should	Completed							24a. Was an	24b Were a	utopsy findings available
Re	The fav	E							autopsy perform	prior to	completion of cause of
a			05 144							No 1 ☐ Yes	No No
Vital	Physician: this certificanal director,	Be	25. Was case refe examiner?		Hospital:		Oth	200	h (Check only one		
of	Phys this ral di	7	1 Yes 2 27. Manner of Dea		1 🗆 Inpati		t 3 DOA	4 LI Nursing Ho			cify)
2		Certification:	1 Natural	5 Pending	28a. Date of Inju (Month, Da	ay Year) 28b. Time of Injury	Wor		28d. Describe how	w injury occurred	
Division	tand leath tor: /	cat	2 Accident 3 Suicide	investigation 6  Could not be			M 1 🗆	Yes 2 □ No			
Ξ	or Attan after deat Director: in by the	E	4 Homicide	determined	286. Place of in	jury · At home, farm, str tc. <i>(Specify)</i>	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or R . State)	ural Route Number,
	ital c	S			4						
	To the Hospital or Attanding within 24 hours after death.  To the Funaral Director: After completely filled in by the fune	edical	29a. Certifier (Check only one)	1☐ Certifying Phy 2 Medical Exam	sicien: To the best iner: On the basis of and manner si	of my knowledge, death of examination and/or invated.	n occurred at the tir restigation, in my o	me, date and place, opinion, death occur	and due to the car red at the time, da	use(s) and manner at te and place, and due	s stated. e to the cause(s)
	Fo th withir Fo th	Me	29b. Signature and	title of certifier			29c. Licens	se number	29	d. Date signed (Mont	th, Day, Year)
	- > - 0		▶ A	Olll	Saa un	Mus -	1001	4206	M	arch 5, 20	208
•			20 Non	any 711	Me Pils	JPUE CONT	0-1-4)	,			
			RENA MA	N ()	ompresed cause of	death (Item 23a) (Type.	14 Pelled	1011111111	DI D.	-1 DIN 11	12101-
			31. Date filed (Mor	nth, Day, Year)	M VI MI	dr's Signature	TUTUK	DIVINO	Ma DE	X MIK PY	7 310/5
	Sta Registr		,	, Day, 19dl)	o Regist	ar s Signature	and a second			,	
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Registrar DHMH 17 Rev 1/2001 MAR 13 2008

LAMBERT

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Of No.	Ce	ertificate of D			g. No. 2008	08/65
	Dhysisi		1. Decedent's Name (First, Middle, Last)	1 2.5			2. Date of Deat Month	n Day Year	3. Time of Death
	Physicia /Medic	al	PAULETTE	LOVE	T # 611 7	- 15 - 4 D - 11	N	1ar 8, 2008	12:02 p <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and numbe		4b. City, Town, or L		chen	4c. County of Death	I/A
- 1	Cuperal		5. Social Security Number 6. Sex 7. A	<b>Court</b> Age <i>(In yrs. last birthd</i> a			8. Date of Birth	9. Birth	place (State or Foreign
*	Funeral Director		216-62-9970 1 M 2 X F Usual Residence of Decedent	53 Yrs.	Months Days	Hours Min.	(Month, Day, Aug 6,		intry) Maryland
	yland Iow at	İ	10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
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	items	nue	11. Marital Status  1 ■ Never Married 2 ■ Married  12. Was Deceder Armed Force 1 ■ Yes 2 ■	nt Ever in U.S. 13 s?	B. Was Decedent of His If Yes, specify Cuban	n, Mexican, Puerto I	Rican, etc.)	Black, White	
36	ırs afi al'', or xami	by F	1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates		1 ☐ Yes 2 ☐ No	Specify:		Specify:	Black
21215-0036	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	cedent's Usual Occupative kind of work done di	tion	na l	16b. Kind of Business/I	ndustry
218	ithin 7 se. nan "r	nple	Elementary/Secondary (0-12) College (1-40	or 5+)	ve kind of work done du . DO NOT use retired)			Own	Home
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Maryland	ntal F ed ot ed ot	Be	James Love			To. Moulei o Hame	,	et Richardson	
7	should nd Me mark matic	은	19a. Informant's Name/Relationship (Type. Print)	19b. Ma	illing Address (Street a	nd Number or Rura	<u>-</u>	; City or Town, State, Z	lip Code)
	nd 2 suith ar 27 is r trau		Nikiya Thomas		4223 Thayer Co	ourt Baltimore	, Maryland	21225	
ľe,	of Hear Item		20a. Method of Disposition	comptany c	position (Name of rematory or other place		ate	20c. Location - City or	Town, State
E	Pages nent of I ant; If Ite ary or or		1 □ MBurial 2 □ Cremation 3 □ Removal from Sta 4 □ Donation 5 □ Other (Specify)		It. Zion Cemete	ry	03/14/08	Lansdowne	e, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ODCe.		21. Signature of Funeral Service License	7	22. Name and Address	•	el Contino	D A	
	20 E # 9		23a. Part1. Enter the disease, or complications that cause	12-1A-	1300 Eu	rothers Funer Itaw Place Ba	di Service, Itimore, Ma	21217	Approximate
			shock, or heart failure. List only one cause on pact	line.	A /				Approximate Interval Between Onset and Death
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	Examiner			as a consequence of):	01.5100				
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P.0.	t the c by the achec	hysi	9 ☐ Unknown 9 ☐ Unknown	n			7		
S, F	The law requires that the death cer tte has been signed by the attendin page 2 should be detached for use	oy P	Part II. Other significant conditions contributing to death	h but not resulting in the	e underlying cause give	n in Part I.		bacco use contribute to	
ord	equire sen sig ould b	Completed by	rast Dyphil	15			1)X(Y	es 2 No 3 Pr	robably 4 □Unknown
ec	G G CI	ple					24a. Was a autop	sy prior to	utopsy findings available completion of cause of
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Division or Vital Records,	Phys er this eral di	To	1 ☐ Yes 2 No 1103pital: 1 ☐ Inp 27. Manner of Death 28a. Date of I	Injury 28b. Time	e of 28c. Injury	4 LI Nursing no		ow injury occurred	City) 1 0 2 1 1 0 2
ion	Attending F r death. ector: After by the funer	tion	1⊠Natural 5 □ Pending (Month, 2 □ Accident investigation	Day Year) Injur		r? Yes 2 □ No			
Vis	or Attendafter death Director:	Certification:	3 Suicide 6 Could not be 28e. Place of	injury - At home, farm, , etc. (Specify)	street, factory, office		28f. Location (S City or Tow	treet and Number or R n, State)	ural Route Number,
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only (Check only of the basis	is of examination and/o	eath occurred at the tim r investigation, in my op	ne, date and place, pinion, death occur	and due to the or red at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the complete	Med	one) and manner  29b. Signature and title of certifier	stated.	29c. License	number		29d. Date signed (Mon	th, Day, Year)
	Vity No.		I ACD as ha Ki	Laun-	-MA D	428=	36	3.10.	08
	1.		30. Name and address of person who completed cause of	of death (Item 23a) (Tyr	pe, Print)	1-0-	X		<u> </u>
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 9:30 LILLIAN G LAVIN 2008 MARUT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 05/16/1911 1□M 2XF Months Days Hours Min Director 215-10-6351 96 MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 □ Yes 2 \ No Director BALTIMORE MD PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 WOODHOLME AVENUE 21208 Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2☐No Yes, Give 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 ☐ Yes 2 🕅 No Specify Specify. þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 SALESPERSON DEPARTMENT STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental I **GOODMAN** PHILIP SARAH LEVIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Health a cortant: If item 27 is injury or other trains JUDITH L. SILVERSTEIN / DAUGHTER 2902 TERRY DRIVE, APT. C, BALTIMORE, MD Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages ' 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CONG. 03/12/2008 BALTIMORE, MD SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 21. Signature of Funeral 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute disease or condition resulting in death) /Medical Due to (or as a consequen of) Examiner Sequentially list conditions, if any, leading to firmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit and Due to (or as a consequence of): physician the burial Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) signed by the a P.0. ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performe certificate 1□ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: P 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manyler of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) March 11th 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RETSTENSTOWN MP MAIN STREET State Registrar

08-01919 Kelly Mosely Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Rea. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day March 8, 2008 Physician/ 0419 hrs Medical Examiner Kelly Anne Mosely c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Country) Mary Land **Funeral** Days Hours Months 5. 1966 Jan. Director 212-84-9061 1 M 2X F Yrs 42 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 X No Chester Queen Anne's 10g. Citizen of What Country? Director 10f, Zip Code 10e. Street and Number narked other than "natural", or items 23a or 28a-event, the Medical Examiner must be notified at United States 21619 1206 Cox Neck Road 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces' 1 Never Married 2 Married Yes Specify: White 1 Yes 2 X No specify: 4 X Divorced If Yes. Give Year 3 Widowed 16b. Kind of Business/Industry 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Itimore, MD 21215-0036

t. Pages I and 2 should be filed within 72 hor timent of Health and Mental Hygiene.
rtant: If item 27 is marked other than "nan Elementary/Secondary (0-12) College (1-4 or 5+) Retail Sales Clerk 1 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charlotte E. League John W. Clark, Sr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 2 514 Arsan Ave, Fl#2, Baltimore, MD 21225 Kristi L. Jenkins - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, West Arundel Crematory Burial 2 X Cremation 3 Removal from State t: If i 3-12-2008 Odenton, MD Department of Important: injury or oth 4 Donation 5 Other Specify
21. Si at of Funeral Service cer 22. Name and Address of Facility Ambrose Funeral Home, Inc. Fact 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** ailure. List only one cause on each line Death /Medica a. Mixed drug intoxication Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit AMENDED 23a, 27, 28a-f per ME g878 4/2/08 amh sician/Medical physician a X UNPENDED law requires that the death certificate be 23d Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Year 3 Ectopic pregnancy Day 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown þ 24b. Were autopsy findings available Completed 24a Was an ficate has been s page 2 should b prior to completion of cause of autopsy death? performed? certificate has 1 🗸 Yes 2 ✓ Yes 2 No 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Other<sub>4</sub> Be Nursing Home 5 Residence 6 Hospital: 1 / Inpatient 2 DOA ER/Outpatient 3 this 2 No 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Yes 2 X No Natural Division Pending <u>Unknown</u> Director: 3/8/08 Unknown Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 1208 Coxneck Rd. 6 X Could not be 3 Suicide fo the He within 24 hours
To the Funeral Dialely fille determined (Specify)Home Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 9, 2008 O.C.M.E. orlend 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 MAR Registrar

DHMH 17 Rev 1/2001 **OCME 2006** 

OCME

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month WILLIAM February 14, 2008 10:05 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Homewood Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept 9, 1936 9. Birthplace (State or Foreign Country) **Funeral** Months unk 1**X** M 2□ F 71 Director 213-34-7096 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show at ns 23a or 28a-f sh must be notifled Director Y⊟Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code unk | 10g. Citizen of What Country? 507 Dawson Street IISA or items 23a 12. Was Decedent Ever in U.S. Armed Forces? u
1 ☐ Yes 2 ☐ No unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status Pages 1 and 2 should be filed within 72 hours after dinent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or item ury or other traumatic event, the Medical Examine. Black, White, etc. unk 1 ☐ Yes 2 ☐
If Yes, Give
Year or Dates: 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: black ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk Be ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2700 N. Charles Street Bsltimore, MD Future Care Homewood 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Buria! 2 ☐ Cremation 3 Removal from State Department o Important; If any injury or once, 4□Donation 5\NOther (Specify) in state 21. Signatur Funeral Service Livensee Roma Le S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 23a. Parkl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 Yes 2 No. 9 Unknown s been signed by i should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No page 2 autopsy perform certificate 1∐ Yes 2 🗷 No or Attending Physiclan: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury 27. Manner of Death 28b. Time of After 4 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 1½ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MUSICIAN 2- 29-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1940 W. SANDHU, MD BALTIMORE ST, BALTIMORE, MD &1223 31. Date filed (Month, Day, Year) 32 egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAR 13

2008

			1- For State of Maryland			f Health a of Death	ınd Mer		ene . No. 2 (	008 08 69
	1. Decedent's Name (First, Middle, Last)							Date of Death		3. Time of Death
	Physici /Medic		$\sim 10^{-1}$							Year 9-50P M
	Examir		4a. Facility Name (If not institution, give street and number)	f Death		4c. County	y of Death			
			Long Green Center		Baltim				Ba1	Ltimore
Е	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la 1214-62-8629 55	Yrs.	Months Da	ear If Under 2 lys Hours	Min	Date of Birth (Month, Day, Y	(ear)	9. Birthplace (State or Foreign Country) unk
-	Director		Usual Residence of Decedent				Me	ar 26,	1932	
	yland now		10a. State 10b. County 10c. City,	Town or Loc	cation					10d. Inside City Limits
	a-f sl	ctor	MD Baltimore	Baltin	nore					1 □ Yes 2 □ No
	or 28	Director	10e. Street and Number		10f. Zip Cod			10g		What Country?
	ath w		115 E. Melrose Avenue			21212			US	
	items	Funeral	11. Marital Status unk 12. Was Decedent Ever in U.S Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 2 No	. 13. V	Nas Decedent f Yes, specify (	of Hispanic Orig Cuban, Mexican,	jin? (Specify , Puerto Rica	Yes or No- an, etc.)		ce - American Indian, ick, White, etc.
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S	alth an 27 Is r		Long Green Center	1		ose Ave				21212
	iges 1 and it of Health If Item 27 or other tr		20a. Method of Disposition 20b. Pla	ace of Dispos	sition (Name o	f	Date			- City or Town, State
more,	0 0 th		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☒ Other (Specify) in State	metery, cren	natorý or other	place)				
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m	an De		mn////		1timor		21201	,55 11 1	JUL CIN	
			23a. Part1. Enter the disease, of complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ente	er the mode of	dying, such as o	cardiac or re	spiratory arrest	t,	Approximate Interval Between
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	/Medical Examiner		Due to (or as a conseque	ence of):	_					4.2
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	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury		ODNIC	REA		. 6		
,	execu n and al-tra	Examiner	that initiated events resulting in death) Last C. Due to (or as a conseque		1	- KEH	(1 / /	<u> </u>		Nap
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9	rtifical ng phy as th	fedi								
Box	leath certific attending p for use as	an/N	IF FEMALE: 23b. Was decedent pregnant   23c. If yes, outcome pf pregnant   1 □Live birth 2 □ Fetal of the control of the co		Ectopic pregna	ancv				ate of delivery
		Physician/Me	1 Yes 2 No 4 Pregnant at time of dea		Other (specify				Me	onth Day Year
о. О	res that the de signed by the a be detached	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not result	ting in the ur	derlying cause	given in Part I		23a Did tohar	CO USA CON	tribute to the cause of death?
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Ž.	rsician: The law s certificate has l irector, page 2 s				<del></del> -		-	24a. Was an autopsy performe		Were autopsy findings available prior to completion of cause of death?
<u>ta</u>			25. Was case referred to medical		1□ Yes 2□ No 1□Yes 2□ No					1 ☐ Yes 2 ☐ No
5	ysicie s cer direct	To Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	t 3 DOA	26. Place of Death (Check only one)  3 DOA Other: JUNursing Home 5 Residence 6 Other (Specify)				ner (Specify)
ō	og Ph ter thi		On Date (Linear Control of Contro							
<u> </u>	endir eath. or: Ai	atic	2 Accident investigation			1 ☐ Yes 2 ☐ N	lo			
Division or	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, off	ice		Location (Stree City or Town, S		ber or Rural Route Number,
	pital vurs a eral C		29a. Certifier 1 Certifying Physician: To the best of my know	dodgo doeth			()	d A. Ab	(-) 1	
	24 hc 24 hc E Fun etely	edical	29a. Certifier 1☐ Certifying Physiclan: To the best of my know (Check only one) 2☐ Medical Examiner: On the basis of examinatic and manner stated.	on and/or inv	estigation, in r	ny opinion, deat	n place, and th occurred a	at the time, date	se(s) and m e and place,	anner as stated. and due to the cause(s)
	To the Hospital or Attending Physician: whith 24 hours after deals. To the Funeral Director: After this certifica completely filled in by the funeral director; to	Med	29b. Signature and title of certifier		29c, Lic	ense number		29d	. Date signe	ed (Month, Day, Year)
			Speake MD		0	0057	150			
7			30. Name and address of person who completed cause of death (Item 2	23a) (Type, I	Print)		, , ,		L PT THE	0 0000
			30. Name and address of person who completed cause of death (Item 2)  Sha Kun male suche 963  31. Date filed (Month, Day, Year)  Registrar's Signature	0 50	enha	to Kg	Suci	1-e 110	000	lumble -
	Sta Registr	v 1	31. Date filed (Month, Day, Year) Registrar's Signatu MAR 1 3 2008	ire Appar	SE !					40 4043

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2008 Samuel Lee Mathews Month Year \*Physician 3:12 A M March 11, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Timonium Stella Maris Hospice Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 MD 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months XM 2□ F 217-36-2971 67 4,1940 December **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show Examiner must be notified at Baltimore Reisterstown 1 Yes 2 No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21136 U.S.A. 6 Brookebury Drive Apt. 1B "natural", or items 23a Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXXVI If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married White 21215-0036 1 ☐ Yes 25 No ≥ Year or Dates 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Plumbing Elementary/Secondary (0-12) College (1-4or 5+) Plumber and Mental Hygiene. 7th Is marked other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Stanley E. Mathews, SR. Pearl Lawson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21136 19a. Informant's Name/Relationship (Type. Print) 6 Brookebury Drive Apt. 1B Reisterstown, MD Lois Mathews (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/13/08 Catonsville, MD Metro Crematory 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Balto, MD 21211 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed la pe Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Vear in the past 12 months? 5 Other (specify) ned by the ☐Yes 2☐No 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 X Unknown MATHEWS nis certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Yes 2**X** No 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 ☐ Nursing Home 5 ☐ Residence 6 M Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day, Year) 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a the Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation is true reliable to the cause (s). 29a. Certifier Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

3:10

MARCH

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

TARIQ MAHMOOD 31. Date filed (M 2008 Physician

/Medical

Examiner

Director MD

Funeral

Completed by

Be

Examiner

Be Completed by Physician/Medical

Certification: To

Medicai

29a. Certifier (Check only one)

29b. Signature and title of certifier

30. Name and address of person

Please T	ype or Print in B	lack Inc	delible Ink	Ensure A	Il Copies	Are Legible		
	State of Maryland				•	_	•	
1 - For State Registrar	State of marytane		tificate of			eg. No.O A A	0 00171	
Decedent's Name (First, Middle, Last)					2. Date of Dear	th	3. Time of Death	
Daniel		Mara	aulies		March	Day Ye	or 17 33 M	
4a. Fecility Name (If not institution, give s	treet and number)		J	Location of Death		4c. County of D	-0	
The Johns Hopkin	& Hospital		Baltin	nove Cit	4	Baltimo	re City	
5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year) 9.	Birthplece (State or Foreign Country)	
331-58-6063	M 2□F 40	Yrs.			07/20	/1967 II	-	
Usual Residence of Decedent  10a. State 10b. County	10c City	. Town or Loc	ration				10d. Inside City Limits	
,							1 ☑ Yes 2 ☐ No	
MD Prince Ge	eorges Hya	ttsvil				0. 000		
10e. Street and Number 6005 43rd St.			10f. Zip Code 20781-			Og. Citizen of What United St		
11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)		merican Indian, /hite, etc.	
1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:		☐ Yes 2 No	Specify:		Specify: W		
15. Decedent's Educ			ent's Usual Occup		cina	16b. Kind of Busine		
Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	OO NOT use retired	•		Higher Ed	ducation	
, , ,	4	Physi	cal Scie	nce Techn				
17. Father's Name (First, Middle, Last)				18. Mother's Nam		Maiden Sumame)		
Seymore Margulies				Cecile				
19a. Informant's Name/Relationship (Typ						; City or Town, Stat	e, Zip Code)	
C. Elizabeth Young-				Hyattsv			-	
20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	metery, crem	sition (Name of latory or other plac ke Cremat		Mar 11	20c. Location - City  Beltsville	e, Maryland	
21. Signature of Funeral Service Lidense	mann		Name and Address app Funer 33 Gist A	ss of Facility al & Crema ve. Silve	tion Ser er Spring	vices , Maryland	20910-	
23a. Part1. Enter the disease, or complications, or heart failure. List only on timmediate Cause (Final	cations that caused the death e cause on each line.	. Do not ente	or the mode of dyin	ig, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death	
disease or condition resulting in death)	Due to (or as a consequ	some offi	actence	MINNO!	Mean	91-	1 days	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Large co	20 lex	mplan	<b>19</b>			3 weeks	
that initiated events resulting in death) Last   Due to (or as a consequence of):  d.								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3□	Ectopic pregnancy Other (specify)	,		23d. Date of Month	delivery Day Year	
Part II. Other significant conditions con	tributing to death but not resu	lting in the un	derlying cause giv	en in Part I.	23e. Did to	-	e to the cause of death? ] Probably 4 □Unknown	
					24a. Was a autops perfor	y prior		
25. Was case referred to medical examiner?	omital: A C		i a		th (Check only or	е)		
TU Yes 218140		R/Outpatient		4   Nursing no		ence 6 Other (S	Specify)	
27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1 🗆	yat k? Yes 2 □ No	28d. Describe ho	Bd. Describe how injury occurred		
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre	eet, factory, office		28f. Location (S. City or Town		r Rural Route Number,	

within 24 hours effer death. To the Funerel Director: After this certificete hes been signed by the completely filled in by the funeral director, page 2 should be detached

State Registrar Priscilla Brastanos, The Johns Hopkins Hospital, 600 North Wolf Street
31. Date filed (Month, Day, Year) 32. Aggistrar's Signature

**MAR 13** 

32. Registrar's Signature

Suchanas, Medical doctor who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Res-000

29d. Date signed (Month, Day, Year)

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Wichols . 25pm **Physician** elores /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Overlea Health & Rehab Baltimore 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03-13-1931 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Months Days unk 213-32-2312 Yrs. Director Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Eraminer must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ty⊡ Yes 2□ No Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21206 6116 Belair Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk unk 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Overlea Health & Rehab 6116 Belair Road Baltimore, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or 4 □ Donation 5 ☒ Other (Specify) in state State Anatomy Board 655 W. Baltimore Street "Wade Director 21201 Baltimore, MD base, of demplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC CARDIOVAROUAR DISEME /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit Due to (or as e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury P.O. Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown signed by Division of Vital Records, ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? cate has been sig page 2 should b Be Completed 2LINO 1LIYES 2 No TLI Yes this certificate 25. Was case referred to medical examiner? 26. Place of Peath (Check only one) funeral director, Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 Natural 5 Pending investigation ours after death. neral Director: Aft filled in by the fur 1 🗌 Yes 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiéi Medicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ce MD 00060560 ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who compa BACK RIVER NECK RS # 109, BALTIMIRE 291 PANICAT

Registrar

State

08-01724 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Charles Francis Oliver State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day February 29, 2008 1219 hrs Medical Examiner Charles Francis Oliver 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Howard Columbia 7070 Cradle Rock Way If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) Funeral Country)West Foreian Months Days Min. Hours Director 1 XM JAN 19. 192-05-0390 93 1915 <del>Virginia</del> Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 Yes 2 X No Columbia notified at once, MD Howard Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shor or other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner must be notified at once 10g. Citizen of What Country 10e. Street and Number 7070 Cradlerock Way, 21045 Apt. USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Married 2 X Yes No 3 X Widowed 4 Divorced If Yes. Give Year Yes 2 X No specify Specify: White þ WW15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 12 Accountant <u>Accoun</u>ting 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Oliverio Benito <u>Giramonte</u> Marianna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oliver, daughter 5435 Wooded Way Janice M. Columbia. MD 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition crematory or other place) 1 Burial 2 X Cremation Removal from State Department of Important: I injury or oth 03/13/08 Metro Crematory, Inc. Baltimore, Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee George MacNabb Cremation Society of MD, 299 Frederick Road Baltimore. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease <sup>⊂</sup>xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27 per MD g879 5/2/08 amh X UNPENDED red by the attending physician detached for use as the burial Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. \$ 1 Yes 2 No 3 Probably 4 V Unknown Completed has been si 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? certificate h 2 No Yes 2 1 🗸 Yes 26 Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: 1 DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 this ۵ 1 🗸 Yes After the 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 1 X Natural 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier **OCME** March 1, 2008 O.C.M.E.

State Registrar

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

DHMH 17 Rev 1/2001 OCME 2006

Theodore M. King, Jr., MD.

31. Date filed (Month, Day, Year)

Name and address of person who complete ause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 2008 **Physician** Wanda Christine Orms 2:15 p /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Owings Mills Baltimore 922 Academy Ave. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Dec. 1931 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Maryland 1 □ M 2 🕅 F 76 216-28-1898 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Owings Mills Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 922 Academy Ave. 21117 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐Mo If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black. White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Title Business Automobile 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Chester Pogonoski Helen Latwinski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1505 Olmstead St. Baltimore, MD. 21226 David Smith - brother in law Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or or XX Burial 2 Cremation 3 Removal from State All Saints cemetery 3/14/08 Reisterstown, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Funeral Service Licensee . Hith hells 11605 Reisterstown Rd. Owings Mills, MD. 21117 Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prohable **Physician** INOUR MYOGARDIAL INFARCTION /Medical Due to (or as a consequence of): Examiner YPERCHOLESTEROLE MIA YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due (or as a consequence of) Examiner and L The law requires that the death certificate be executed Due to (or as a consequence of) signed by the attending physician a d be detached for use as the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes → No 24a. Was an has e 2 page performed? res 20 No certificate 1□ Yes To the Hospital or Attending Physician: 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Tes 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA P this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 No Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one)

State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR 13 2008 Maga4Kall

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROLANDO VIEVA MD

YORK ROAD LUTHERVIlLE Md ZIO93 32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

2008

			1- State of Maryland / State of Maryland / per dr., g877,03/	Department of Health and M 13/08dhb Certificate of Death	lental Hygien Reg. N	2008 08176				
	Physici	an	Decedent's Name (First, Middle, Last)  I		2. Date of Death Month D Control Contr	3. Time of Death  Unknown				
1	/Medio Examir		William D. O'Neill  4a. Facility Name (If not institution, give street and number)	County of Death						
	Funeral	è	5. Social Security Number 6. Sex 7. Age (In yrs. last b)	rthday) If Under 1 Year II Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign				
	Director		213-12-4163	Yrs. Months Days Hours Min.	July 27,	1914 Maryland				
	aryland show	_	10a. State 10b. County 10c. City, Tov	n or Location		10d. Inside City Limits				
	the M	recto	MD Baltimore (	Catonsville 10f. Zip Code	10g. C	1 Yes 2 No				
	ath with	rai D	715 Maiden Choice Lane CR616	21228		USA				
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at ance.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☒ Yes 2 □ No If Yes, Give Year or Dates: 141-46	13. Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerlo  1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White				
15-0	n 72 ho "natur adical	ieted	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b.	Kind of Business/Industry				
212	ed withi	Completed		ublic accountant	8	government				
Maryland 21215-0036	ould be fill Mental H arked oth	To Be	17. Father's Name (First, Middle, Last)  Michael Francis O'Neill		e (First, Middle, Maide et Anne Ger					
ary	2 shou and M is mar	-	The state of the s	o. Mailing Address (Street and Number or Rura						
	1 and Health tem 27		20a. Method of Disposition 20b. Place of	715 Maiden Choice Lan of Disposition (Name of		e, MD 21228 Location - City or Town, State				
ltimore,	Pages ment of ant: if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)	nry, crematory`or other place)						
Ball	Depending the point of the poin		21. Signure of Funeral Sovice Licensee Wade, Director	State Anatomy Board		ltimore Street				
			Baltimore, MD 21201  23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate Interval Between							
j	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Atheroscle  Due to (or as a consequence		sease	Onset and Death  year				
	Examiner	_	Sequentially list conditions, b.							
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ol):						
60,	ficate be executed physicien and s the burial-transif		resulting in death) Last Due to (or as a consequence	of):						
68760		ledical	d							
P.O. Box	The law requires that the death certif He hes been signed by the attending tage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome ol pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year				
	w requires that been signed b should be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?				
Vital Records,		Completed			24a. Was an autopsy performed?					
	ysiclar is certif directo	To Be	25. Was case referred to medical examiner?  1  Yes 2 Hospital: 1 Inpatient 2 ER/O	Other	me 5 Lesidence	6 □Other (Specify)				
0 0	ing Ph		1 ☐ Natural 5 ☐ Pending (Month, Day Year)		28d. Describe how inj					
Division of	i Qifte	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)		28I. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)				
	To the Hospital within 24 hours a To the Funeral I completely filled	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination are and manner stated.	e, death occurred at the time, date and place, ad/or investigation, in my opinion, death occurr	and due to the cause( ed at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)				
	To the within 2 To the complet	Me	29b. Signature and ritle of certifier	29c. License number		ate signed (Month, Day, Year)				
•			While & the MD	D47009	Fe	bruary 26,2008				
_			30 Name and address of person who complete cause of death (Item 23a)	den Choice Lo	me Bal	bruary 26,2008 timore, MD21228				
	Sta Registr	te ar	31. Date filed (Mesta Cay. Year) 2008 32. Registrar's Signature	Spark						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Physician 2: 20 AM 2008 MARCH Maud L. Pippin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HOSPITAL N/A SAINT AGNES If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days Min. 1 □ M **XX**F Yrs MD212-40-8469 Director 09-16-1910 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. Cify, Town or Location show If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🕅 No Director MD Baltimore Arbutus 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1008 Plover Drive United States 21227 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify: Specify: White \$ 3 Nidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Erson Leaverton Marjorie Roe 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is n any injury or other traun once. Maud Colgain - daughter 1008 Plover Drive, Arbutus, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition March XXBurial 2 ☐ Cremation 3 ☐ Removal from State Easton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Old Spring Hill Cem. 14, 2008 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Funeral Service Licensee MO1378 MMP, Inc., 7250 wash. Blvd.

236 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MMP, Inc., 7250 wash. Blvd., Elkridge, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) 12 hours **Physician** /Medical Due to (or as a consequence of): Examiner 24 hours MESENTERIC ISCHEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ending physician and use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1☐ Yes 2XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Division or Attending 5 Pending investigation 1 Natural M 1 ☐ Yes 2 ☐ No 2 Accident after death i Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie P19384 MARCH, 11, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
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. Registrar's Signature

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31. Date filed (Month, Day, Year)

S CATON AVE. BALTIMORE, MD. 21229

Physician
/Medical
Examiner

with the Maryland r 28a-f show notified at "natural", or items 23a or permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Ite Medical the Ith and Mental Hygie

27 is marked other

traumatic event, tt

Saltimore, Maryland 21215-0036

**Physician** /Medical Examiner

other

Injury or

burial-trar and P.O. Box 68760. physician the been signed by should be detact Records, Division or Vital after death To the Hospital within 24 hours a To the Funeral D

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 6:48 PM MAGZGARET Prescon 2008 MARCH 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death RANDALLSTOWN BAZTIMORE COUNTY HOSPITAR CENTER MD NORTHWEST If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03-12-1932 Social Security Numbe Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. Hours 1 □ M 2 🙀 F ountry) MD 213-34-6870 Director 75 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits Directo 1 ☐ Yes 2 No Lansdowne MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 United States 3208 Bryant Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. 2 Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert E. Smith Margaret Smith ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Prescott - Husband 3208 Bryant Ave., Lansdowne, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State NBurial 2 ☐ Cremation 3 ☐ Removal from State March 13, 2008 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park Elkridge, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Gary L. Kaufman Funeral Home at M01378 MMP, Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a Part1 Enter the disease, shock, or heart failure. r or obligations hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on rone consecutions. Immediate Cause (Final disease or condition resulting in death) CARDIAC APRRYTHMIA WITH APRREST MALIGNANT Due to (or as a consequence of): CORONARY ARTERY DISCAS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) HYPERTONSION Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 ASDOMINA WALL HURNIAS - RUCURRINT, MUCTIPLE 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an Were autopsy findings available prior to completion of cause of ABDOMINA autopsy death? 1 ☐ Yes performe <u>ANTEROCUTANEOUS</u> FISTURA 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a Date of Injury 28h Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D36132 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21 CROSSROADS DRIVE SUITE 360 COUNTS MILLS, MD ZILLZ RICHARD P. FRANKLIN MD 31. Date filed (Month, Day, Year) 32 egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** MARGARETTA PRICE MARCH, 5:40 AM 2008 /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Ridgeway Manor Nursing & Rehab Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 27, 1918 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2以F 89 Pennsylvania Director 168-05-6037 Usuel Residence of Decedent death with the Merylend 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at tv Yes 2 □ No MD Baltimore Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3308 Benson Avenue Funerai 21229 USA 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygione. Important: If item 27 is marked other than "nature" any injury or other traumatic acceptance. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specity: Specify: \$ 3 X Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) plant manager glass manufacturing 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Sommer Theresa Dieter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Winifred Price/daughter 305 Burnside Court Joppa, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition emetery, cremetory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☑ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
State Anatomy Boad 655 W. Baltimore Street 21201 Baltimore, MD Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical RECURRENT STROKE TWO MONTHS **Examiner** Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 第 Unknown HYPERTENSION WITH Be Completed by HYPERTENSIVE CARDIOVASCULAR HYROIDISM DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? CHRONIC KIDNEY DISEASE STAGE 3 2 No 1 ☐ Yes 2 ☐ No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No Medicai Certification: 27 Manner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d Describe how injury occurred 5 ☐ Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide within 24 hours of To the Funeral I To the Hospitai 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Yeer) 29b. Signature and title of certifier Komal D0018362 tr. Daw 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) 3455, Wilkens Ave. Ste LIO. Battimore, Md 21229 Komal k. Dans M.D.

Registrar

State

31. Date filed (Month, Day, Year)

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32. Registrer's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 0730 POWELL 2008 CHARLES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 2, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1₩ M 2□F Washington DC 75 Director 578-42-1744 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Hyattsville Prince George's MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20782 USA 6500 Riggs Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: white Maryland 21215-0036 'natural", or If Yes, Give Year or Dates: 1 ☐ Yes 2 💢 No Specify: 2 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 sheet metal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk ages 1 and 2 should be fill out of Health and Mental Hit: if Item 27 is marked oth y or other traumatic evenity. Be 2 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WAashington, DC 1234 Franklin Street NE Richard Jenkins/friend Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 Removal from State permit. Page Department o Important: if any injury or 4 ☐ Donation 5 ☑ Other (Specify) in state Signature of Euneral Service Licer State Anatomy Board 655 W. Baltimore Street Wade Di rector ell 21201 Baltimore MD 23a. Part1. Enter the disea, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Embiremen Lung /Medical Due to (or as a consequence of): Examiner SA Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for es a consecuence of Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying gause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed' certificate 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To s after death.

I Director: After this d in by the funeral d 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Hospital or Attending To the Hospital or within 24 hours aft To the Funeral Di completely filled in

> State Registrar

31. Date filed (Month, Day, Year)

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29b. Signature and title of certifier

usach War,

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

D63703

29d. Date signed (Month, Day, Year)

SARU, MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Items 28b, 28d, f per me 88/8 4-14-08 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year Queen 0904 /Medical -amont 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore ころいいいか Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex In yrs (ast birthday) **Funeral** 9. Days Hours 1 1 M 2 □ F Director Usual Residence of De permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Town or Location 10d Incide City Limits 'naturai", or items 23a or 28a-f show Examiner must be notified at Director 1 Yes 2 No 10e. Street and Numb 10f. Zip Code 10g, Citizen of What Country? by Funeral 14. Race - American Indian Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 1 1 Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 3 D Widowed 4 Divorced Completed any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) is marked other than College (1-4or 5+) 18. Mother's Name Fathe s Name (*First, Middle,* Be ျ Department of Health and Important: If item 27 is ma Gity or wn, State, Zip Code) Address (Street and Number or Rural Route Number. Ultrie 20b. Place Method of Disposition 20. Location, Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 2) Signature of Funeral Service Ligeny 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mide of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ardia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 31 Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transi and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, signed by the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hem othoraces 1 🗌 Yes 2 100 3 Probably 4 □Unknown page 2 should After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ 100 24a. Was an autopsy 1∐ Yes 2 46 To the Lospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No P 1 TYes 1 🔲 Inpatient 2 ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: 20533, of Motor Ventcle Crash (Month, Day Year) 1 Natural 5 ☐ Pending investigation 2 Accident Suicide 09/28 1 TYes Director 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Randal Istown MD 28f. Ld 4 Homicide hours after Funeral 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) within 24 and manner stated the 29b. Signature and title of contifier 29c. License number ٥ 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 Whent 31. Date filed (Month, Day, Year) nistrar's Signature State MAR 13 Registrar 2008

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Emma Mae Virginia Reihl 8:30 P M 2008 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1834 Simms Lane Hanover Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🛛 F Director 194-20-5952 3, Dec. 1928 Maryland Usual Residence of Decedent within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2 X No Anne Arundel Hanover Director 10e. Street and Number 1834 Simms Lane 10g. Citizen of What Country? 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be 1 **2107**6 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐Yes 2X No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: White 3 Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the M 6 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Wells Nora Boyle 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Harold - Daughter 1834 Simms Lane, Hanover, MD 21076 200. Place of Disposition (Name of eemetery, crematory or other place). Crestlawn Memorial 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 3-12-2008 Marriottsville, MD Cardens Tame and Address of Facility Ambrose Funeral Home, Inc. Signatu e of Funeral Service L 12/19 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Enelso perculo Physician acciden /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed and I-tran Due to (or as a consequence of): physician a s the burial-1 P.O. Box 68760. Physician/Medical attending p as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed рееп 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? page this certificate 1∐ Yes 2□No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 HV 1 Inpatient 3□ DOA 2 ER/Outpatient ို 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital

Registrar

(Check only one)

harles

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR 13

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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32. Registrar's Signature

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Huy Ste. 106, Gilen Burnie,

29d, Date signed (Month, Dav. Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🛭 🖺 Certificate of Death 2. Date of Death 3. Time of Death **Physician** Elizabeth Jane Ray 20451M 10 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 🛠 🔀 F 217-26-0303 79 Director 9-5-1928 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f shov edical Exa<u>miner must be notified at</u> MD 1 XYes 2 No Director N/A Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3838 Roland Avenue Apt. #1207 21211 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 200 No Specify by Specify. ¥X Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Macy's than, Elementary/Secondary (0-12) College (1-4or 5+) all l Retail Sales Department Store 8th 7 Is marked other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Hiant: If item 27 Is marked oth Anthony Richard Litzinger Nellie Elizabeth Mules 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 239 Glen View Terrace Abingdon, MD 21009 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tn James E. Ray 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Lorraine Park Cemetery 3/15/2008 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign June of Funeral Service licens 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc 3631 Falls Road Baltimore, Maryland 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to r s a consequence of): Examiner Sequentially list conditions, if any, loading to immodute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Penph. Micher burial-transit The law requires that the death certificate be exec Physician/Medical the as IF FEMALE: for use a 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 23d. Date of delivery 3 ☐Ectopic pregnancy 1 ☐Live birth 2 Fetal death Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed 1⊟ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient Certification: To 1 Inpatient 3□ DOA 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural Injury 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after dea To the Funeral Directo completely filled in by the 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe

Division or Vital Records, P.O. Box 68760,

Maryland 21215-0036

Baltimore,

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DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gardhelle

1003 Robert

29d. Date signed (Month, Day, Year)

your Menund

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year. CM **Physician** March 12/5 RUBINSTEIN 2008 10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore City of Baltimore Sinci Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 3irthplac Country) MD 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 2 🕇 F 02/21/1917 218-09-6589 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyghene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notitied at once. 1 ☐ Yes 2 No BALTIMORE MD BALTIMORE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21208 130 SLADE AVENUE, APT. 417 by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: WHITE Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DINOWITZER MORRIS ROSENBERG EDYTHE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 130 SLADE AVENUE, APT. 417, BALTIMORE, MD 21208 MYER RUBINSTEIN / HUSBAND Baltimore, 20b. Place of Disposition (Name of MI KRU KUDESH BETH ISRAEL CONG. 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) BALTIMORE, MD 03/12/2008 21. Sign or of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complication Approximate Interval Between Onset and Death us that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) 20 days Sepsus Physician /Medical Due t (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760. Completed by Physician/Medical IF FEMALE If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death Month Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 | Yes 2 No 3 | Probably 4 | Unknown directe Coronary artery 24b. Were autopsy findings available prior to completion of cause of 24a. Was an heard Congestive certificate has b rector, page 2 sl autopsy performed2 Yes 2∐No death? 1 ☐ Yes 2 No 1□ Yes the Hospital or Attending Physician; 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

The Funeral Director: A pletely filled in by the 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifler RES - 000 March 10, 2008 Ocinataun. MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oana Pauso, Sinai Hospital of baltimore

DHMH 17 Rev 1/2001

State

Registrar

MD

2008

32. Signature

**ORIGINAL** 

31. Date filed (Month, Day, Year) MAR 13

Rubinstein,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2008 5:00A Elmer H. Stein, Jr. March 6. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 101 Charles Road Linthicum Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2 □ F 84 10 1923 Maryland Director 215-14-7839 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 🎇 No Directo Anne Arundel Linthicum 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Charles Road 21090 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify: White <u>Ş</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Truck Driver Transportation marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event Be Elmer Henry Stein Sr. Marie Bender 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wife 101 Charles Road, Linthicum, MD 21090 Helen Josephine Stein -20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other 3 Removal from State Cedar Hill Cemetery 3-7-2008 5 Other (Specify) Brooklyn, MD of Funeral Service Lice 22. Name and Address of Facility Ambrose Funeral Home Inc. 1328 Sulphur Spring Rd., Arbutus 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 1+UU~ MUCCARDIM /Medical Due to (or as a consequence of) Examiner Antiznoscullun Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of) the attending physician hed for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending

Baltimore, Maryland 21215-0036

24 hours after death Puneral Director: Hospital To the

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

127838 518 CAMP MINNIN ROAD, CINITHICUS.

JOHNI 31. Date filed (Month, Day, Year)

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year March **Physician** Erma Naomi Sadler 2008 5,00 /Medicat 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) 1918 Baltimore , Agnes hos 1 Year 5. Social Security Number 6. Sex Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 212-05-2037 1□ M 2▼F 89 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 □Yes 2 No MD Baltimore Director Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1717 Rittenhouse Avenue 21227 United States Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No White ģ 3√2 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Herr Helen Herr nee Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau Michael Remeikas - Grandson 1929 Hilltop Rd., Jessup, MD 20794 20b. Place of Disposition (Name of centetry, crematory or other place)
West Arundel
Crematory
22. Name and Address of Facility Ambrose Funeral Home, Inc. 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Signature of Furieral Service Licenses 1328 Sulphur Spring Rd., Arbutus, MD 21227 P.m. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy perform the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes € No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

Division or Vital fo the within 24 hours — the Funeral Dire

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760.

Medical 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 13 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nos. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2008 MARLH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMINE LEMEN RANDAZUSTIWN HOSP)541 If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 01/24 Birthplace (State or Foreign Country) **Funeral** 232.68.2258 1 □ M 2 7 F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at Baltimore Windsor Mill MD 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Circle 21246 7805 "natural", or items 23a arme Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: 3 Widowed 4 Divorced or than "natura the Medical E 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Callege (1-4or 5+) Private Domestic 1 year nt of Health and Mental Hygis

If Item 27 is marked other

or other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Madae ဂ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Windsor Mill, MD 21244 irde Husband Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (*Specify*) Memorial 03/13/08 Baltimore, MD
22. Name and Address of Facility Laughn C. Greene Funeral Services 03/13/08 Department of Important: If any Injury or once, Arbutus 21. Signature of Funeral Service Licenses M01363 Road Randall stown MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ARTTRIDSCLEAPTIL CARDIOVASCULAR Physician /Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): Box 68760, attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an ate has page 2 s autopsy perform To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ R/Outpatient 3 ☐ DOA Medical Certification: To filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) 0002497D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

CLIFF FABER

31. Date filed (Month, Day, Year)

MAR 1 3 2008

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RANDALLKOWN,

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egistrar's Signature

020

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #25 Per State of Maryland / Department of Health and Mental Hygiene
Certificate of Death
Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 11:20 PM EWART SEPH March 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner H WES NO TOWN NDA-LL: If Under 24 Hrs. 8. Date of Birth (Month, Day, . Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 ⅓M 2 ☐ F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or home any Injury or other trainment. 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Funeral Director MARYLAND 10e Street and Number 10f Zin Code 10g Citizen of What Country? 15A ace - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ▼Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 THGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (M ม - ย ม หมองเบป) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROLV KANDALLSTOWN, MP 21244 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of or other place 1 Burial 2 □ Cremation FOREST 03-14-08 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee TR. FUNERAL HOME Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEP515 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner End Stase Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9□Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1☐ Yes 2☑No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Impatient 1 ☐ Yes 20XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ဥ this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) thysicia 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

REISTENSTOWN MD

25 MAIN STREET

2. Registrar's Signature

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31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** TEK MARCH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner TOWSON BALTIHORE 31LCHRIST HOSPICE CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. 5. PT 0 4, 11 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** 1**X** M 2□ F Months 218-76-913 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show notified at 1XYes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 0 must be or items 23a 14. Race - American Indian, Black, White, etc. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or ite Iny or other traumatic event, the Medical Exa<u>mine</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TOHN 5. WILSON CO. INC. 12 THGRADE RIVER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 5 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Hural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of the Important: If Ite any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State BALTIHORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Addre ALTO. MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER METASTATIC **Physician** LUNG MONTHS disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy for Month Day Vear 5 ☐ Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown has been 24a. Was an autopsy performed?
1 Yes 2 1 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 this certificate or Attending Physician: 25. Was case referred to medical examiner? funeral director. Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS PLEE 2No 1 🔲 Yes 1 | Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 Ratural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

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State

To the

9:6

MAR 13 2008 Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DANIEUE ABBERMAN, ALD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

164395

29d. Date signed (Month, Day, Year)

MARCH 12, 2008

BALTIMORE, NO 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year **Physician** 1200AM 200 March Michelle Annette Seth /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Agnes HUSBITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 23,1962 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 6. Sex 5. Social Security Number **Funeral** Days 1 □ M 2 🖾 F Maryland 220-72-9451 45 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland Catonsville Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 7 Three Willows Court 21228 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Specify: White altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: <u>۾</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Restaurant Server 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Jane Buddemeyer Joseph Sierakowski ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7 Three Willows Court; Catonsville, Maryland 21228 Husband Earl W. Seth 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 3/13/2008 Catonsville, MD Metro Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee MD 21228 1630 Edmondson Avenue; Catonsville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 36 days Physician encepha! /Medical Due to ( as a consequence of): Examiner Hepato-Tenal if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ysician and e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Perneral Director; After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit 4 curte rana Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, SEA SUS Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death Month Day ☐Yes 2 12 No Michelle 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 🗹 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P22256 March, 12, 2008 Fethi Benraouane

Registrar
DHMH 17 Rev 1/2001

State

St Aprils

3 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Benraouane

MAR 13 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** 6:59 PM Leslie Smith MARCH 09 08 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL BALTIMORE N/A AGNES 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Social Security Number 6. Sex Funeral Months Days Hours 1 **₩** 2 **F** Jan 3, 1952 Maryland Director 56 220-76-3217 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 □**X**es 2 □ No Owings Mills Director **Baltimore** Marvland 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 21117 200 Rosewood Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 □ **1x**o Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) **Never Worked** Elementary/Secondary (0-12) Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Smith Arthur C. Smith ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2753 Woodmont Drive York, Penn. 17404 Dennis Smith Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 ☐Removal from State permit. Page Department o Important: If any Injury or 03/15/08 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Western Cemetery 21. Signature Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Farf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA 2 MONTHS RECURRENT Due to (or as a consequence of): ATRIAL FIBRILLATION PAROXYIGMAL > 2 MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): > 2 MONTHS HYPERTENSION Due to (or as a consequence of): > 2 MONTHS DISORDER Physician/Medical SEIZURE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Donknown 1 🗌 Yes TRACHEDSTOMY DISTRESS REQUIRING 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 W No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ▼No 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical **Examiner** 

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'natural", or items 23a

traumatic event, the Medical Examiner must

than

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Pages 1 and 2 nent of Health a

Injury or other

3altimore, Maryland 21215-0036

be notified

attending physician and for use as the burial-tran signed by the a page 2 should certificate I funeral director, Certification: To

27. Manner of Death

1 Natural

2 Accident

3 Suicide 4 🗌 Homicide

(Check only one)

31. Date filed (Month, Day, Year)

29a. Certifier

that the death certificate be executed P.O. Box 68760, or Vital Records, Division Hospital or Attending · death.

within 24 hours after death

To the Funeral Director:
completely filled in by the f

Medical

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

P 21800

29d. Date signed (Month, Day, Year) 09,2008 MARCH

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury

(Month, Day Year)

MATHEW PULICKEN, 900 S. CATON AVENUE, BALTIMORE, MD 21229

28b. Time of

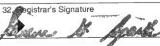
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

MAR 13 2008

5 Pending investigation

6 Could not be



# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Maryla		artment of I		d Mental	Hygie	ne nn	8 08	192
*			Registrar  1. Decedent's Name (First, Middle	, Last)		Cei	rtificate of	Death	2. Date	Reg. of Death	No.	3. Time	of Death
	Physici /Medic		Philip		SH	Cinan			Mont 0 3	h		ear 304	AM M
	Examin		4a. Facility Name (If not institution LEVINDALE HEB				4b. City, Town, 6		eath		4c. County of	Death	
i i	Funeral	_	5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year	If Under 24 h	Hrs. 8. Date	of Birth th, Day, Ye		A Birthplace (State	e or Foreign
	Director		214-24-6176 Usual Residence of Decedent	1 <b>□</b> M 2□F	80	Yrs.	Months Days	Hours N	6in. 04/2	9/192	27	Country) MD	
	yland how at		10a. State 10b. County		10c. C	City, Town or Lo	ocation					10d. Inside	1.7
	he Mar 8a-fs	Director		TIMORE		BA	LTIMORE						s 2 No
	death with the Maryland rms 23a or 28a-f show r must be notified at	Ē	10e. Street and Number  1 GRISTMILL C	OURT, APT	. 205		10f. Zip Code 2120	8		10g.	Citizen of Wha		
	ems 2	Funeral	11. Marital Status	12. Was Dec	cedent Ever in	U.S. 13.	Was Decedent of I		(Specify Yes	or No- c.)	14. Race - American Indian, Black, White, etc.		
0036	irs afte	by Fu	1 □ Never Married 2 ☑ Marr 3 □ Widowed 4 □ Divorced	ed 1 🛣 Yes If Yes, G Year or I	2∏No iive	T T	1 □ Yes 2 【XNo				Specify:	WHITE	
2	72 hou natura dical E		15. Deceden (Specify only highe	's Education		(Give	dent's Usual Occu kind of work done	during most of	workina	16b	. Kind of Busir	ness/industry	
7	within ene. than "	Completed	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retire ATTORNEY	ed)			LAW		
anaz	e filed al Hygi other vent, t	Be Co	17. Father's Name (First, Middle,				MITORICET		Name (First, M	fiddle, Maid	den Surname)		
ylai	ould by Ments	To	ABE		SHERM				NN		FRI		
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentle Hylgene. Impartment of Health and Mentle Hylgene. Internative it eme 23a or 28a-f show any injuriant: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relations BETTE SHERMAN				ng Address <i>(Stree)</i> GRISTMIL				-		21208
ore,	of Hee		20a. Method of Disposition 1 X Burial 2 □ Cremation	3 DRemoval from	20b.	Place of Dispo	psition (Name of ESH or other pla		Date			ty or Town, State	
Dallimor	it. Pages rtment of l rtant: If ite njury or of		4 □ Donation 5 □ Other (S	pecify)	BE	TH ISRA	EL CONG.	03,	/12/200	18 NGC		ORE, MD	
D D	Depar Impor any ir		I Signature of Furneral Service	TAINAR	4		2. Name and Address 8900 REI					OS., INC LE, MD 2	
Ng 1		8	23a. Part1. Enter the disease, or shock, or heart failure. List	complication that only one of se on	caused the dea	ath. Do not ent	ter the mode of dy	ng, such as care	diac or respirat	tory arrest,		Approxim Interval B	ate etween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	RMINA	, ,	nochess	ive Do	MENT	IA		Onset an	o Death
	Examiner			-	or as a conse		12 PLEOC.	TOSIS !	OF INTE	TERN	INATE	RIGIN	
7	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a conse	equence of):							
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	certifica ding ph	/Med	IF FEMALE:	23c If yes or	utcome pf pregi	nancy							
YOU .	death death	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live 4□Preg	birth 2□Fe nant at time of	tal death 3	⊒Ectopic pregnand ⊒ Other <i>(specify)</i> _	У			23d. Date of Month	,	Year
5	at the	Phys	9 ☐ Unknown	9□Unki					- 1				
colds,	w requires that the death certific been signed by the attending I should be detached for use as	by	Part II. Other significant condition	ins contributing to a	Jeath but not re	esulting in the u	nderfying cause gr	ven in Part I.	23e.	Did tobaco		ute to the cause o	
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VII	sician certifi irector	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	Inpatient 2	⊒ER/Outpatier	t all DOA Oti		Death (Check				
5	ig Phy ter this neral d	$\vdash q$	27. Manner of Death	28a. Date		28b. Time of Injury	II 3 L DOA	ry at	g Home 5  28d. Desc		e 6 ∐Other njury occurred		
2	ttendir leath. ttor Al the fu	catio	1 Natural 5	ation			M 1	Yes 2□No	00/			B 48 4 W	
5	alor A	Certification:	4 ☐ Homicide determ	ned 28e. Plac build	ding, etc. (Spec	cify)	eet, factory, office		City o	tion (Street or Town, Si	tate)	or Rural Route Ni	imber,
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours alter death.  Within 24 hours alter death.  To the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier (Check only one) Certifyin 2 Medical	g Physician: To th Examiner: On the and mai	e best of my kr basis of examir nner stated.	nowledge, deat nation and/or in	h occurred at the to vestigation, in my	ime, date and pl opinion, death o	lace, and due to	to the cause time, date	e(s) and mann and place, an	er as stated. d due to the cause	e(s)
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	10		BABATUN DE	AJAN	am il	2	434 W- E	SELVEN	FRE A	1. BA	titimor	+ MD 1	1215
	Sta Registr		31. Date filed (Month, Day, Year)	3 2008 32.	Registrar's Sign		berte						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 28 200 Herbert Charles Willkomm Jr. Februar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Medica Plata a Civista | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. March 10, 1962 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1XM 2□ F Months 45 California **Director** 569**-**51**-**4340 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene. Important: If them 27 is anxied other than "naturali" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Waldorf Charles Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20601 3090 Old Washington Road 12. Was Decedent Ever in U.S. Armed Forces? 1981 1 XYes 2 □ No If Yes, Give Year or Dates: 1997 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Trucking Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara Ann Weinhold Herbert Charles Willkomm 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Willkomm, Son Elbestrabe 61C, 55122, Mainz, Germany Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 03/10/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lignsee
Thomas Gregor 2Cremations Soctety Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pulmonary Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Cardiovascolor Disease atheroscieronic Sequentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Congr shv x

Due to (or as a consequence of): the death certificate be executed Records, P.O. Box 68760, Copo attending physician Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 21110 1 ☐ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? within 24 hours after death.

Fo the Funeral Director: After it completely filled in by the funeral 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide ь within 24 hours a To the Funeral L 1 🗸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2/29/2008 auto Brome 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) La Plata Marita Broome St MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State REAR P 13 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 91, State of Maryland / Department of Health and Mental Hygiene (1) Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 10:00 AM M 4, 2008 Margaret Harned Wright March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Friends Nursing Center Sandy Spring
If Under 1 Year | If Under 24 Hrs. | 8, D Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🔀 F Yrs. Director 87 07/14/1920 578-28-5898 Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City. Town or Location ?7 le marked other then "netural; or iteme 23a or 28e-f show treumatic event, the Madical Examiner must be notified at 1 K Yes 2 No Directo Sandy Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "neture!" ~-" any injury or other treumatic event. United States 20860-Funerai 17340 Quaker Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Specify: White 1 Tyes 2N No Specify: þ 3 ⊠ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Real Estate College (1-4or 5+) Elementary/Secondary (0-12) Broker 17. Father's Name (First, Middle, Last) 18. Mother's Name /First. Middle. Maiden Surname) Edna Johnson Robey Wentworth Harned 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44 Orchard St. Pleasantville, NY 10570-Melanie Wright Tripp/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Mar 7 Beltsville, Maryland \* 4 □ Donation 5 □ Other (Specify) 2008 Chesapeake Crematory 22. Name and Address of Facility 21. Signature of Euneral Service NO0382 Rapp Funeral & Cremation Services Shout dolumens Silver Spring, Maryland 20910-Gist Ave. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ARTERIOSCLEROTIC CARDIOVASCULAR years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Quelto for as a papsaquence off-Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) cate has been signed by , page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28c. After 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours an 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physicien:

with the Maryland

(

State Registrar

(Check only one)

30. Name and address

DENJA

29b. Signature and title of certifier

R 13

2008

29c. License number D 0838 29d. Date signed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print) 20832 PRINCE PHILIP DR: CLNEY MD 18111

MD 32 Registrar's Signature ASSIAL.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Williams **Physician** me:s much /Medical 4a. Facility Name (If not institution, give street and number) Town or Location of Death Examiner 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months 1X M 2□ F 217-38-2292 **Director** 68 11/01/1939 MARYLAND Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show ns 23a or 28a-f shor must be notified at 1X Yes 2 □ No MD Director N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 623 GEORGE STREET, APT. 1 USA 21201 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married Specify: BLACK 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. þ 3 ☐ Widowed 4 ☑ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BALTIMORE CIT BUBLIC SCHOOL SYSTEM (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE ENGINEER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CATHERINE BOND VERNON ALLEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 3705 YOSEMITE AVENUE, BALTIMORE, MD 21215 SHERI WILLIAMS / DAUGHTER of Health item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any Injury or conce. 1X Burial 2 □ Cremation 3 □ Removal from State 3/13/08 LAUREL, MD MD NATL MEM. PARK 4 □ Donation 5 □ Other (Specify) 21. Signature of Great Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death or the disease, or complications that caused the death heart failure. List only one cause on each line. Immedia: Caus (Final disease r covition resulting ath) **Physician** emmortag /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, the. IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 1 ☐ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ပို 1 patient 27. Manner of Death 1 atural 2 Accident 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, To the Hospital or Attending Physician: after death | Director: / d in by the f within 24 hours a

To the Funeral I

completely filled

State

DHMH 17 Rev 1/2001

Registrar

Medical

29a. Certifier

Date filed (Month, Day,

MAR 13

2008

and manner stated.

(Item 23a) (Type, Print) Hodi

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend, item 12 per fb 9877 3-13-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 4 00 AM 2008 march /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hanes Hospital Baltimore 57 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours Min. 1 M 2 □ F 089-20-3710 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? USA 1002 by Funeral filed within 72 hours after death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1X Yes 2 "natural", or 1 ☐ Yes 2 ☑ No Maryland 21215-0036 Yes, Give ear or Dates: Specify: Specify: African America 3 ☐ Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mastr Carpenter es 1 and 2 should be filed vor Health and Mental Hygie f item 27 is marked other tor other traumatic event, the 17. Father's Name (First, Middle, Last) Pages 1 and 2 should I nent of Health and Men ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19a. Informant's Name/Relationship (Type gate Rd. Apt.3C Young 20b. Place of Disposition Name of Baltimore, Date Method of Disposition
1 ☐ Burial 2 ☐ Cremation 20a. Method of Dispo permit. Pages Department of I Important: If its any Injury or o 3 ☐Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Fune at Service Licens MO1401 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest stock, or heart failure. List only one cause on each line. Immedi te Cause (Final disease or condition resulting in death) day **Physician** cerebral Varsicular /Medical Due to (or as a consequence of): Examiner untenoun carotia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) Ö detached 9 Unknown 9 Unknown ٦. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Records, 2☑No 3☐Probably 4☐Unknown 1 Tyes Hypertension page 2 should hypercho el terolenno 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑Yes 2 ☐ No 24a. Was an autopsy performed' 2 No Vital 25. Was case referred to medical examiner? completely filled in by the funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1. Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To or 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After the Hospital or Attending Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier march 7 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) man lan Baltimore Tao inn 2. Registrar's Signature 31. Date filed (Month, Day, Year)
MAR 13 State 2008 Registrar

DHMH 17 Rev 1/2001

08-01909 Clarence Arches

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		н	919 Leeds	Road					Elkton			0.01 10	Data of Diet			Rithola	ce (State or Foreign
Fune			5. Social Security I	Number	6. Sex	7. A	ge (In yrs. las	st birthday)	If Under		If Under Hours	Min			- 1	Country	)
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CO we law	2 2	g												formed?		eath? ✔ Yes	2 No
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of \	After the	⊢	27 Manner of D			28a. Date of (Month, D	Injury Day,Year)	28b. Time	of Injury		ury at Wo	_	28d. Describ		iry occurre	:d	
ion tendir	eath. or: ⊿ the fu	흝	1 Natural 2 Accident		nding estigation	3-7-	2008	4:1			Yes 2X		unkno		- d Niverbo	ar Bur	al Route Number, City
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he Ho	within 24 h To the Fun completely	ig Ig	(Check only 1	Certifying  Medical E	aminer: On	the basis of	examination	and/or inve	stigation, in i	my opinic	on, death	occurred a	at the time, da	ate and pla	ice, and du	ue to the	cause(s)
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			30. Name and a	artiress of pers	on who com	oleted cause	of death (Ite	em 23a)			. =						
			Pamela E	E. Southall,	MD As	ssistant M	nedical Ex	aminer	111 Per	n Stre	et, Balti	ımore, N	MD 21201				
		State	9.31. Date filed (A	10 MARY T	71 200	8 32. 5	gistrar's Signa	ature	book								

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	<b>ST</b> 10		Decedent's Name (First, Middle,	Last)							2. Date of D		S.pag	Veer	3. Time of	Death
1.je	Physici /Medic		Henry A. Badget	t							Februa	ry Ž	Š, 2	2008	3:15	P M
Ciw.	Examin		4a. Facility Name (If not institution,		nber)		4b. City,	Town, or	r Location	of Death				ty of Death		
	×.		13124 10th Stree				Bowi			0411			rino	ce Geo		
1	Funeral			3. Sex 1 <b>X</b> M 2□ F	7. Age (In yrs.	last birthday) Yrs.	Months		If Under Hours	Min.	8. Date of B	av. Year	2,,	Coui	olace (State o ntry)	r Foreign
Щ.	Director		227-70-1668 Usual Residence of Decedent		63	110.					Oct. 2	Z, I	944	virg	inia	
	land ow		10a. State 10b. County		10c. Cit	y, Town or L	ocation							1	0d. Inside C	ity Limits
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9	after or It	F	1 ☐ Never Married 2X Marrie	d 1 ☐ Yes If Yes, Giv	2 <b>⊠</b> No e		1 ☐ Yes		Specify:				Spec	cify:		
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparament of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationshi	p (Type. Print)		19b. Mail	ing Address	s (Street	and Numb	er or Rur	al Route Num	ber, City	or Tow	n, State, Zij	Code)	
	1 and 2 Health a em 27 is ither trai		Margaret Badget	t/ Wife					reet		e, MD					
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	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Certification:	<u></u>	1								,				
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	<b>7</b> <u>₹</u> S	7	29b. Signature and title of certifier	man D	min									·		
	Fala	V	20 Name and address (	U 1 7	o of death (II	m 22a\ /T: ~		D231	81			Feb	rua	ry 26	, 2008	
	XXXX		30. Name and address of person v		Gorman			re1	MD 2	20707	#T-1					
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Exar Funer Direct	nine al	44) Facility Name (If not institution) give street and number)  DHAT WAS ASSOCIATED ASSO	Months Dave Hours Min	4c, County of Death  1. Date of Birth (Month, Bay, Year)  1. Date of Birth (Month, Bay, Year)  1. Date of Birth (Month, Bay, Year)  2. Birthplace (State or Foleign W. Virginia
and ww	et	Usual Residence of Decedent  10a. State 10b. County 10c. City, To	own or Location	10d. Inside City Limits
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with th a or 28 be no	2	10e. Street and Number 574 Welland Ct.	10f. Zip Code 21108	10g. Citizen of What Country?  USA
s 1 and 2 should be filed within 72 hours after death with the Maryland feetalth and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married	13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No- can, etc.) 14. Race - American Indian, Black, White, etc.
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d2sh thand thand 171sm traum		19a. Informant's Name/Relationship (Type. Print) Alicia Dorsey Blackmon(Wife)	9b. Mailing Address <i>(Street and Number or Rural)</i> 574 Welland Ct. Mil	Route Number, City or Town, State, Zip Code) Llersville, Md. 21108
is 1 and 1 tem 2		20a. Method of Disposition 20b. Place	of Disposition (Name of Dai tery, crematory or other place)	
Pages ment of l ant: If Ite			land Veteran 2-29-	
permit. Departi Imports	ouce,	21. Signature of Funeral Service Licensee	Amame Rands of Scilisons 821 West St. Anna	-
***		23a. Part1. Enter the disease, or complications that caused the death. D	L	respiratory arrest Approximate
Physicia	n	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	TIS	Interval Between Onset and Death
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w require been sig should by				1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
The law r cate has be page 2 sh	olumo,			24a. Was an autopsy performed?  1 Yes 2 Sho   24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 Sho
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o the Hospital or Attending Physician: within 24 hours after death. o the Funeral Director; After this certifics completely filled in by the funeral director;	i i i o o i i i i	27. Manner of Leath    X   Natural   5   Pending investigation     2   Accident   5   Could not be determined     4   Homicide	M 1 Yes 2 No	il. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital or Attendin within 24 hours after death.  To the Funeral Director; Aft completely filled in by the fur	o loci	29a. Certifier (Check only Medical Examiner: On the basis of examination		
To the within 2 To the comple	Mod	29b. Signature and title of certifier	29c. License number 60796	29d. Date signed (Month, Day, Year)
1110		30. Name and address of person who completed cause of death (Item 23s	a) (Type Print)	Emo 2/061
	State		DIED , OCH GUNNE	21001
Regi	stra	LER S. J. COUR Branch St.	Soule	

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death O 2 **Physician** 2125 M VIRGINIA BROWNING 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** <u> Anne Arundel Medical Center</u> Anne Arundel <u>Annapolis</u> If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 02–11–1924 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Director 219-12-3310 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show iral", or items 23a or 28a-f shov Examiner must be notified at 1 □Yes 2 No Director Deale <u>Anne Arundel</u> 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Madical Evantage. USA 20751 6036 Drum Point Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ 3 X Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Estelle Taylor Sr. Nettie ျှ Jesse Hugh Trott. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Linden Avenue, Edgewater, MD 21037 Karen Browning George, daughter Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XI Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cemetery 03-06-2008 Cheltenham, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final asper Physician disease or condition resulting in death) /Medical nsequence of): Examiner CVA Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine or Attending Physician: The law requires that the death certificate be executed physician and stransit that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 1 ☐ Yes 2 No 9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. ģ 1 🗌 Yes 2 **N**O 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To After this 27. Manner of Death 1 V Natural 2 ☐ Accident 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number D 21438 February 29 2008
23a) (Type-Print)
445 DEYENSE HEAWAY ANNAPOW MOZIKO) ed cause of death (Item 23a) (Type Print) JRN 6 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 28<sup>Day</sup> Month **Physician** 2008 0032 a M Feb. Felicita M. Brzovich /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days | Hours | Min. | May, 4 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 78 May, Peru 216**-**37-7469 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TyYes 2 □ No Directo Maryland Prince Georges Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Peru 20706 7313 Green Oak Terrace Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 □ No If Yes, GiveX Year or Dates: 1 Never Married 2 Married Specify: white X Yes 2□No SpecifyPeruvian ð 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Miguel Bocanegra Maria Palma ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7313 Green Oak Terrace Lanham, MD 20706 Diana Brzovich (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Chesapeake Crematory March 3, 2008 Beltsville, MD 5 Other (Specify) 4 Donation uneral Service Licensee 22. Name and Address of Facility 21. Signature Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD. 20706 Enter the disease, or which tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. Liston one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) a End-Stage Renal Disease years Due to (or as a consequence of): 2 Diabetes Mellitus years Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 🗖 No 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Acute pancreatitis, Alzheimer's Dementia, 25 No 3 Probably 4 □Unknown hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 2 X No 1 ☐ Yes 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

The law requires that the death certificate be executed physician and s the burial-transit Division or Vital Records, P.O. Box 68760, attending pl the s been signed by the should be detached page 2 s certificate To the Hospital or Attending Physician: After this Director: hin 24 hours a

**Funeral** 

Director

show

"natural", or items 23a or 28a-f shedical Examiner must be notified

Medical

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mportant: If item 27

**Physician** 

/Medical

Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

within 2 State Registrar DHMH 17 Rev 1/2001 one)

29b. Signature and title of certifier

Barbara A.

Darbara

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

ORIGINAL

29c. License number

D0065485

Spital 1500 Forest Glen Rd. SS

29d. Date signed (Month, Day, Year)

MAR 0 3 2008

Spaganich

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 6:08 A M ARBARA ANBAB MARCH 200 X /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner MEDICAL GLEN V. BURNIE ARUNDEL JASHINGTON ENTER HNNE (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2▼F Months Days Hours Yrs MARYLAND Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show ortant; If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number -5-4 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: altimore, Maryland 21215-0036 Specify. 3 ☐ Widowed 4 ☑ Divorced DAITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TOMEMAKER HOWATEL Department of Health and Mental Hygis Important: If item 27 is marked other 1 any injury or other traumatic event the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SCHEMM S HNN 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 Removal from State RDENT CREMATORY 9-08 HANOVER, MA 4 □ Donation 5 □ Other (Specify) 21. Signatura f Fu 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 Pant. Enter the disease or complications that eached the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** UDITABABBAKE UPOD 2YAO OI /Medical Due to (or as a consequence of) Examiner SEVERE COPD 10 YEARS Sequentially list conditions, if any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner o (or as a consequence of be executed burial-transi 20 YEARS SHOKIHG Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð UOIZZZA930 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 【No 24a Was an certificate has page 2 No 1□ Yes Division or Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending i within 24 hours after death.

To the Funeral Director; After Certification: 5 Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Children José Grang pour HD

Registrar

31. Date filed (Month, Day, Year)

MAR 1 4 2008



DHMH 17 Rev 1/2001

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MARCH 8, 2008

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			For State Registrar	State of Mar	yland /		ent of Hea ate of De			21	008	08204
	11	4	Registrar     Decedent's Name (First, Middle, La	ast)		OCTUNO	are or be	, attr	2. Date of De	eath		3. Time of Death
	Physici /Medic		Jerome O. Broder						Month Februar	Day 21, 2	Year 2008	1522 м
	Examin	er	4a. Facility Name (If not institution, gi	ve street and number)		4b. C	ity, Town, or Lo	cation of Death			ty of Death	
-		1000	Suburban Hospital  5. Social Security Number 6.	Sov. 7 Ago	(In yrs. last I		Bethesda der 1 Year   If	Under 24 Hrs.	8. Date of Bir		tgomen	
- 10	Funeral Director			1 1 M 2 □ F	(iii yrs. iast i 34	Yrs. Mont		Hours Min.	(Month, Da	in, Year)	Cour	
	ס		Usual Residence of Decedent						NOV. 9	1923		
	arylar show d at	-	10a. State 10b. County	1	10c. City, To	wn or Location					1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
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9	after or ite		1 ☐ Never Married 2 🔀 Married	1 ☑ Yes 2 ☐ No		i		Specify:	riidari, etc.	Spec	ack, White,	
Ş	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	d b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E	Year or Dates:	0.00	a. Decedent's l	Isual Occupation			16b. Kind of I	wnı	
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pu	be file tal Hy d othe event	Be	17. Father's Name (First, Middle, Las	t)			18			, Maiden Surna	ame)	
ryla	d Men narke natic	ပ္	William Broder  19a. Informant's Name/Relationship	(Time Brint)	1.	9b. Mailing Add	rana (Street and	Tillie	<u>-</u>	as City as Taur	- Ctata Zia	Cada
Maryland	nd 2 sl Ith an 27 is r traur	1 8	Hessa B. Broder -			600 Ewi				•	n, State, Zij	(Code)
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition			of Disposition (			Date	20c. Location	- City or To	own, State
Baltimore,	Page nent c		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec			David M		s. 2/24	/2008	Falls (	Church	, Virginia
3alt	Departi Departi Importa any inj		21. Signature of Funeral Service Lice	ensee		22. Nam Edwar	e and Address of Sage1	Funera	l Direc	tion, I	Inc.	
_	20780	11	222 Part 1 Enter the disease or con	Totter	ryer	<b>-</b> 11091	Rockwill	le Pike	Rockvi	11 <sub>e</sub> MT	2085	
	Physician	١.	23a. Part1. Enter the disease, or cor shock, or heart failure. List onl Immediate Cause (Final					suori as caraiao		arrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Cervica:  Due to (or as a			ure	11			(D) 8	nF
	Examiner		Sequentially list conditions.	b	1			X	_V(	mp		
di h	pe sit	ine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a	conse veno	ce of):	$\sim$	12/1		1	~	
0	executed n and ial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequenc	· Man	0 3	C.	2	27 6	+ <del>C</del> (	
(20 D) 68760,	ding Physician: The law requires that the death certificate be executed n. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	edical		d		11.						
$\sim \sim \infty$	certificate be iding physicia ise as the bur	Med	IF FEMALE:				JI'ST VA			-1		
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à oi	that the de ed by the detached	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	ime or death	3 <u>3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</u>	(specify)					
Fred MF. ords, P.O.	s that med b		Part II. Other significant conditions	•		•	•	in Part I.	23e. Did	tobacco use co	ontribute to t	he cause of death?
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× ×	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatien	t 257 FR/	Outpatient 3	Other		th (Check only	<i>one)</i> sidence 6 □C	Othor (Coope	6.1
1 O.	g Phy er this eral d		27. Manner of Death	28a. Date of Injury (Month, Day		b. Time of Injury	28c. Injury a Work?			how injury occ		197
sior	Attending death. sctor: After	atio	1 □ Natural 5 □ Pending 2 ☑ Accident investigati	on 02/16/20	08   9	:30 A M	1 ☐ Ye	s 2 XNo	Fall o	ut of b	ed	
Division or Vital	or Att	Certification:	3 Suicide 6 Could not 4 Homicide determine	28e. Place of injur building, etc. At Home	y - At home, (Specify)	, farm, street, fa	ctory, office		28f. Location 8600 or E	(Street and Nur Winger Ia, MD	mber or Rur <b>ive.</b> –	al Route Number,
	spital ours a neral I		29a. Certifier 1 ☑ Certifying F	Physician: To the best of	my knowled	dge, death occu	rred at the time,	date and place				stated.
	n 24 h	Medical		aminer: On the basis of e	examination							
	y <b>To the Hospital or Attendi</b> within 24 hours after death. <b>To the Funeral Director</b> ; A completely filled in by the fu	Me	29b. Signature and title of certifier	94	_		29c. License n	umber		29d. Date sign	ned (Month	Day, Year)
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	Regist		FEB 292	008 Bosen	, K	Goods	1					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** 2008 - phruare /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner gional Medical Center Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 F MARYLAND Director 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State show 1 ☐ Yes 2 No must be notified at **Funeral Director** 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò 5 23a 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc "natural", or iten dical Examiner filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 ☐ Divorced Year or Dates 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natun any injury or other traumatic event, the Medical once. HNCOrage Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinent of Health and Mental Hygiene. NUrsino 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JONES Cottman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Gode) Informant's Name/Relationship (Type. Print) 19a daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name.o cemetery, crematory or other place) Date 20a. Method of Disposition -08 Burial 2 ☐ Cremation 3 ☐ Removal from State Beulah, Md Maryland Veterins Com 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Bennie Smit Isabella St 21. Signature of Fin eral Service License salisbury and 21801 Home Funeral Approximate Interval Between Onset and Death sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest filture. List only one cause on each line. 23a. Part1. Enter the shock, or heart Immediate Cause inal disease or condition resulting in death) **Physician** /Medical Examiner Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, vo Vascular Be Completed by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1□Yes 2No the 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 No this certificate 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of filled in by the funeral 27. Manner of Death 28c. Injury at Work? After 1 Injury 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29h. Signature

3M

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEVEN HAMLETTE, MD / DE.

31. Date filed (Month, Day, Year) 32. Pgistrar's Signature FEB 2 8 2008

ars Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March 4,2008 Year 11:10A M Lola Boyle /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Olney Montgomery General Hospital Montgomery if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 □ M 2 X F 78 Director 232-36-3228 August23,1929 Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☑Yes 2 ☐ No Director Parkersburg WestVirginia Wood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ŏ 26101 U.S.A. items 23a 2805 Earl Place Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or Yes, Give ear or Dates: 1 ☐ Yes 🏋 ☐ No Specify 9 Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) the Me Elementary/Secondary (0-12) College (1-4or 5+) Healthcare Nurse is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy V. Smith Anna Frazier P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20833 19a. Informant's Name/Relationship (Type. Print) item 27 i 18700 Heritage Hills Drive, Brookville, MD. Patrick Boyle 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkersburg, WestVir. 4 Donation 5 Other (Specify) Evergreen South 3-8-08 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee 6009 Harford Road Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 0 BAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and the burial-trans Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as SS IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 menths?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy Day 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 210 No 3 Probably 4 Unknown 1 ☐ Yes been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy perform page 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 🗆 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 npatient 2 ER/Outpatient 3∏ DOA this 27. Manny of Death funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

Hospital or Attending Physician: within 24 hours af

To the Funeral D

completely filled in

> Sadik Ali, 251 Antietam Street, Hagerstown MD 21740 2002 Registrar's Signature 31. Date filed (Month, Daty) State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Ty

(Check only

29b. Signature and title of certifier

20

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

29d. Date signed (Month, Day, Year).

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ARION Month 2 DOMES 810 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 5/19/1933 9. Birthplace (State or Foreign **Funeral** M 2 F Months Maryland 218-28-9754 74 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director Maryland | Anne Arundel Davidsonville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or edical Examiner must be 664 W. Central Ave. 21035 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int I flem 27 is marked other than "natural", or Ite Armed Folces: 1 X Yes 2 □ No If Yes, Give Year or Dates: Korea 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No White 2 3 Widowed 4 □ Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Park Ranger Anne Arundel County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Coomes Monna Arrington 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly F. Mauk/ Daughter 1197 Latrobe Dr., Annapolis, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important: if ite any injury or of 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Lakemont Cemetery 2/29/08 Davidsonville, MD 21. Signature of Fureral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 1/1/1 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of d ing, such as cardiacon espiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to in a solution cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical as IF FEMALE use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached the 9 Unknown 9 I Inknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an 1 Ves 2 No I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only D 21438 February 26 2008
DEVENSE HERWAY ANNAPOUS Mp 2140/ FEB 2 Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ora Esther Callahan February 23, 2008 12:58 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year, 5/23/1917 **Funeral** 1□M 2X F Months Days Hours Min 90 Director 233-12-2539 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 28a-f show 1 ☐ Yes 2 X No Director Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1707 Ridgely Rd. 21037 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ Specify: White 3 Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Clerical Worker State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joel A. Pardue Mary G. Barlow ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty A. Cordovilla/ Niece 1707 Ridgely Rd., Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 2/27/08 | Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licensee Mar 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed Due to (or as a consequence of) the attending physician a hed for use as the burial-Division or Vital Records, P.O. Box 68760 Physician/Medical use as t IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown detached signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has t autopsy performed After this certificate 2.7 No Physician: rector, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 1 ☐ Yes 2 No 2 R/Outpatient 3 DOA P uneral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Accident 5 Pending investigation (Month, Day Year) Injury within 24 hours after deau...

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 032036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sprouse, M.D. Gary J. 2108 DiDonato Dr., Chester, MD 21619 31. Date filed (Month, Day, Year) 32. Registrar's Signature Eleve & Spark Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 24 2008 **Physician** Phillip E. Chambers 2017 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 4 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Hours Min. Months Days 1**X** M 2□ F 82 Yrs Maryland Aug 1925 219-16-1016 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits show Examiner must be notifled at Maryland Anne Arundel Annapolis 1X Yes 2 No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ö 1371 Walnut Avenue 21403 USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 □ No Yes, Give 1 Never Married 2X Married 1 ☐ Yes 2 ☑ No Specify. Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Co. than Elementary/Secondary (0-12) College (1-4or 5+) 12th 4yrs Educator Board of Education other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Item 27 is marked o John T. Chambers Sr Ruth Hicks ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, Md. 21403 Helen T. Chambers (Wife) 1371 Walnut Avenue 20a. Method of Disposition 20b. Place of Disposition (Vame of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot once, 1 Burial 2 □ Cremation 3 □ Removal from State Memorial Gardens 3-1-08 Annapolis, Md. 4 Donation 5 Other (Specify) M Mame Ra @ 690 Pacili Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or a) a consequence of): Examiner todes ewnatosi Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner karotic Due to (or as a consequence of) physician at s the burial-t Physician/Medical as attending p IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 1 TVes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No page death? 1 ☐ Yes 2 ☐ No 25. W Be 2 27. M

The law requires that the death certificate be executed Box 68760. P.O. by the a signed by Division or Vital Records, or Attending Physiclan: Certification: After within 24 hours after death

To the Funeral Director:
completely filled in by the the Hospital

with the

Pages 1 and 2 should be filed within 72 hours after death

permit.

Baltimore, Maryland 21215-0036

as case referred to medical			26. Place of De	ath (Check only one)
aminer? ∡≫es 2⊡ No	Hospital: paripatient 2 □	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)
anner of Death ☑Natural 5 ☐ Pending ☐ Accident investigatior		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
☐ Suicide 6 ☐ Could not be ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, fact fy)	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)

FertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEDICC MN

State Registrar

Medical

31. Date filed (Month strar's Signature 7 2008

/Medical **Examiner** 

Examiner Physician/Medical

þ

Completed

Be

ို

Certification:

Medical

IF FEMALE: 23b. Was decedent pregnant

25. Was case referred to medical examiner?

5 Pending

investigation

6 Could not be determined

1 Yes 2 No

27. Manne Death

1 atural

2 Accident

4 Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

24a. Was an autopsy performed

2 No 3 Probably 4 → Nknown

. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 █ No 2 No 26. Place of Death (Check only one) 4□ Nursing Home 5 Residence 6 Hother (Specify) Friends Hame

28c. Injury at Work? 28d. Describe how injury occurred 1 🗌 Yes 2 □ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🗆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

Other:

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

29d. Date signed (Month. Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital: 1 ☐ Inpatient

28a. Date of Injury (Month, Day Year)

Salvador 300 31. Date filed (Month, Day, Year) 32 Registrar's Signature

State MAR 0 3 2008

within 24 hours after death To the Funeral Director:

**Physician** /Medical Examiner **Funeral** 

Director filed within 72 hours after death with the Maryland Director

28a-f show notified at orant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be reading. must be

Funeral

þ

Completed

Be

altimore, Maryland 21215-0036 permit. Pages 1 and Department of Healt Important: If item 2 any injury or other **Physician** 

as the burial-transit and Box 68760. physician use been signed by the should be detached

P.0. Division or Vital Records. has death.

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2:45 P Nellie Alverida Childress February /Medical 27 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10902 Hammond Dr Laure] Howard 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** Davs Months Hours Min 1 □ M 2 X F Oct 11, Director 220 03 1909 86 1921 Maryland Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh notified a 1 ☐ Yes 2 X No Director MD Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o e ral", or items 23a Examiner must b 10902 Hammond Drive 20723 United States by Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced White 'natural". Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Harry Cleveland Ensor Ella Elizabeth Roache ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Moschler/Daughter 6750 Montgomery Rd Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If ite any Injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Lutheran 3-3-2008 Fulton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? 1 Yes 2 No Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but ot resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s autopsy perform 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🙀 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🛣 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🔼 Natural 1 Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely 24 and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 February 29, 2008 86 Lark Brown RND El Kridge 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Régistrar's State MAR 03 2008 Registrar

DHMH 17 Rev 1/2001

	1 - For State Registrar		State	of Marylar		artment of I <i>rtificate of</i>		nd Menta		iene <sub>eg. No.</sub> 2 (	800	0821
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	Bobby Jean					osewood (				, MD 2	_	, , ,
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	21. Signature of Fu	heral Service L	icensee 🔾	100-	/ 22	2. Name and Addre	ess of Facility	Hartzl	er F	uneral	Home	
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State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 25 **Physician** Year 2008 Edgar William Causey Sr. 750 Februari /Medical Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner REGIONAL ENINSULA SAUSKIK 4 NICOMICO If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours 1**™**M 2□F 7/14/1928 Director 220-26-7854 79 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shor traumatic event, <u>the Medical Examiner must be notiffed at</u> 1 ☐ Yes 2 ☐ No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 128 Village Oak Drive 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 2 🛛 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) building contractor construction and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be Larry J. Causey Sr. Kathryn Willis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 Signe R. Causey/wife 128 Village Oak Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place)
Webster Family 20a. Method of Disposition 20c. Location - City or Town, State Department of H 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (*Specify*) Injury or Cemetery

22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804

Approximate Interval Between 2/28/08 Mt. Vernon, MD 21. Signature of Funeral Service Ucensee Kello 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SPIRATION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as ultimated events.) Examiner The law requires that the death certificate be executed burial-trai resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) P.O. | ed by the a ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2□No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DOA this After thi funeral 27. Manher of Death 1 Natural 28b. Time of 28a. Date of Injury (Month, Day Year) Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 24 and manner stated 29b. Signature and title of certifier D0063991

WINF

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State Registrar GN M.O Gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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14/5 S. ONISION ST. Salisbury MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Mont

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Clarence Chappel 2008 0821 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Clarence Ρ. Chappelle March 4, 2008 1254 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Fort Washington Hospital Fort Washington Prince George's If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours oreign Director 064-32-0651 Country New York 1X M 2 F 1942 66 Yrs Feb. 25 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 X No "natural", or items 23a or 28a-f show Examiner must be notified at once. Maryland Prince George Fort Washington death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 12424 Gable Lane 20744 Funeral 11. Marital Status 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 X Yes J № 1960 Baltimore, MD 21215-0036
permit. Pages I and 2 should felled within 72 hours after a Department of Health and Mentae Iffgiene a Important: If item 27 is marked other than "natural", or injury or other traumatic revent. **Black** 4 X Divorced Yes, Give Year Specify: 3 Widowed Yes 2 X No specify: -1<u>966</u> ≥ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Foreman Electrical Engineer 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Preston Chappelle Dorothy Capers Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Tara Chappelle/Daughter 5529 Summer Night St. Las Vegas,NV. 89031 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Maryland Vet. Cemetery 3/14/2008 Cheltenham, Maryland Donation 5 Other Specify: 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licenses 6160 Oxon Hill Rd. Öxon Hill, Md.20745 23a. Eart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** een Onset and /Medical Death a. Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease <sup>∿</sup>≒xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical X UNPENDED 1, 23a, Pt. II, 27 per ME g877 3/20/08 amh attending physician or use as the burial -Box 68760, 23d. Date of delivery IE EEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. ğ 1 Yes 2 No 3 Probably 4 V Unknown Chronic renal disease; emphysema Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy has l death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No certificate 25. Was case referred to medical 26.Place of Death (Check only one) of Vital director Be Other<sub>4</sub> examiner? DOA Nursing Home 5 Inpatient 2 V ER/Outpatient 3 this 1 🗸 Yes No funeral 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 1 X Natural Division Yes 2 No Pending To the Funeral Director: completely filled in by the Accident 2 Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 \_ Could not be Suicide or Town, State) within 24 hours a To the Funeral I determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. March 5, 2008 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201

State Registra

OCMF 2006

DHMH 17 Rev 1/2001

Assistant Medical Examiner

32. Registrar's Signatur

Patricia Aronica-Pollak MD.

31. Date filed (Month, Day Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		ľ	1 - State State of Registrar	Maryland / De	epartment of F Certificate of			ene () () ()	08216
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Alice A. I	)i Pirro			2. Date of Death Month Feb. 26	Day Year	3. Time of Death 2:15 PM
	Examin		4a. Facility Name (II not institution, give street and num National Lutheran F	Iome	Roc	r Location of Death KVille		4c. County of Death Montgome	ery
A. S. S. S. S. S. S. S. S. S. S. S. S. S.	Funeral Director		5. Social Security Number  031-16-0542  031-16-0542  031-16-0542  03XF  03XF	7. Age (In yrs. last birtho	Months Days	Hours Min.	8. Date of Birth (Month, Day, ) eb.11,	(ear) 9. Birth Co. 1926 Mass	place (State or Foreign untry) sachusetts
	Maryland a-f show	ctor	10a. State 10b. County 10c. Md. Montgomery	10c. City, Town o	or Location ockville				10d. Inside City Limits 1 X Yes 2 □ No
-	th with the 23a or 28	al Dire	10e. Street and Number 9701- Veirs Drive		10f. Zip Code	0850	100	g. Citizen of What Cou USA	untry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show any figury or other traumatic event, the Medical Exert far must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes, Giv Year or Da	2X∏ No e	13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 XNo	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	e, etc.
Maryland 21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1 3 Y	(1)	decedent's Usual Occup Give kind of work done ife. DO NOT use retired Register	during most of work d)	ing	Nursino	
land 2	should be filed and Mental Hygi marked other umatic event, I	To Be Co	17. Father's Name (First, Middle, Last) Herbert Longland	10		18. Mother's Nam	e (First, Middle, Mi		
	1 and 2 sho Health and I Iem 27 Is ma		19a. Informant's Name/Relationship (Type, Print)  Michael J. Di Pirro-  20a. Method of Disposition	Son 110	Mailing Address (Street ) 18 Oakwo	od Stree	et, Silv		ng,Md.2090
Baltimore,	mit. Pages 'sartment of hortant: If the injury or of		20s. Method of Disposition  1 □ Burial	cemetery.	crematory or other place olitan Cre 22. Name and Addre	ematory-	2/27/08	-Alexand	ria,Va.
Ba	Departit Departit Importi any inj		23a. Part 1. Enter the disease, or complication; that c shock, or heart failure. List only one cau e on e	aused the deat . To no	Hysong Co	o., Inc.	Jashingt	consin A con, DC	Approximate
	Physician /Medical		tmmediate Cause (Final disease or condition resulting in death)	or as a consequence of	ir bre	ast C	incer		Interval Between Onset and Death
8760,	eate be executed thysician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	or as a consequence of					/
O. Box 6	death certific e attending p id for use as	Physician/Med	in the past 12 months2	come of pregnancy inth 2 Petal death ant at time of death own	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	,		23d. Date of deli Month	very Day Year
S, D	requires that the een signed by th hould be detache	ed by Pł	Part II Other significant conditions contributing to de Secondary Unit Co	eath but not resulting in t	he underlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Division of Vital Record	The law re cate has bee page 2 sho	Completed by	Securday bone	comela			24a. Was an autopsy perform	ed? prior to death?	topsy findings available completion of cause of 2 \( \sum \text{No} \)
Vita	Physician: r this certific ral director,	o Be	25. We case referred to edical examiner?  1 Tyes 2 Tyo	npatient 2 ER/Outp	eatient 3 DOA Oth	00	h (Check only one	) nce 6 □Other (Spec	n/v)
ion of	ding th. Afte	atlon: To	27. Manner of Death  1 Matural 5 Pending (Mont) 2 Accident investigation	of Injury 28b. Tir	me of 28c. Injury		28d. Describe how		,
Divis	ital or Attenirs after deal	Certification:	3 Suicide 6 Could not be determined 28e. Place buildi	of Injury - At home, fam ng, etc. <i>(Specify)</i>	n, street, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	iral Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical	29a. Certifier (Check only one)  Check only one)  Check only and manifer in the base and manifer in the base and manifer in the base and manifer in the base in th	isis of examination and/	death occurred at the till or investigation, in my o	ne, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	Toth within Toth comp	Me	29b. Signature and tifle of certifier	anesh w	29c. Licens	number 72/	29	d. Date signed (Month	28,2008
2	(3)		30. Name and address of person who completed caus	, , ,		a D::	Do miles in the	/	- 1,000
	Sta Registr			Karesh-		s Dr., .	KOCKV11.	re,Ma.	

State Registrar 30. Name and address of person who

Benjamin,

Wayne D.

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

6602 Church Hill Rd. Chestertown,

MD. 21620

completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

			For State Registrar	State of I	Maryland		artment rtificate			Mental Hy	giene Reg. No	2000	082	18
7		П	Decedent's Name (First, Middle, La	ist)						2. Date of De	eath		3. Time of D	Death
Laboration	Physici /Medio		JENNIE		SUBOI	\$				Month O	Da O	y Year S ວິວີວິວີ	06:20	AM
	Examir		4a. Facility Name (If not institution, given	e street and numb	er)		4b. City, T	own, or Loc	ation of Death		40	. County of Death		
			Levindale		A // /-	- 4 l- 1-41- al 1	Balt If Under 1	imore	Under 24 Hrs.	10 D-t( D)				
	Funeral Director			Sex 7. 1 □ M 2 □ F	Age (In yrs. la	a <i>st birtnday)</i> Yrs.		Days H	ours Min.	8. Date of Bi (Month, D				-
	26.		Usual Residence of Decedent		01					Uctobe	eris	,1926 N	orth	car.
	ryland how		10a. State 10b. County		10c. City,	, Town or Lo	cation						10d. Inside City	
	e Ma Ba-f s	Director	Maryland		Bal	timor							1 ⊠Yes	2   No
	vith th	Pig	10e. Street and Number				10f. Zip (				10g. Ci	tizen of What Cou	ntry?	
	eath v	eral	3402 Devonshir	e Drive	ent Ever in U.S	13		215 ent of Hispa	nic Orlain? (Si	pecify Yes or N	U.S	A. 14. Race - Ameri	can Indian.	
39	be filed within 72 hours after death with the Maryland tial Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notitled at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 Tes 2 If Yes, Give Year or Date	es? [ <b>∑</b> No		If Yes, speci	fy Cuban, N	lexican, Puert	Rican, etc.)		Black, White,	etc.	
21215-0036	72 hou	Completed	15. Decedent's E (Specify only highest gr	ducation		16a. Dece	dent's Usual	Occupation	l na mast of war	kina	16b. K	(ind of Business/In	dustry	
21	within 7 lene. than "I	nple	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT use	retired)	ng most of wor	ung	_		GI.	
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Maryland	l be fi	B	17. Father's Name (First, Middle, Las	•					_	ne (First, Middle	e, maidei	n Surname)		
Ž	should be nd Menta marked	٩	John L. Willia  19a. Informant's Name/Relationship			19b. Mailii	na Address <i>i</i>		earl N Number or Ru		per. City	or Town, State, Zij	n Code)	
Z	nd 2 satth ar 27 is r trau		Tyrone R.Hardi							ive,Ba	-		,	
re,	is 1 and the street item	11 3	20a. Method of Disposition		- Ca	ace of Dispo	sition (Name	e of	i bi	Date		ocation - City or T	own, State	
m	Page nent c int: If iry or		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		Zio	nHill	Bapt	istCh	nurch3	-7-08	T.it	tleton	N C	
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ment Important: If item 27 Is marked any injury or other traumatic e		21. Signature of Funeral Service Lice	nsee arribor	_	22	2. Name and	Address of	Facility Ma	rzullo	ς Fυ	neral (	Chapel	
0			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nptreations that cau	sed the death.	. Do not ent	ter the mode	of dying, s	uch as cardiad	or respiratory	arrest,	20,1102	Approximate Interval Betw	/een
	Physician		Immediate Cause (Final disease or condition	ATHERE						Bise			Onset and D	eath
	/Medical		resulting in death)	With the same of t	as a conseque									
	Examiner	Ļ	Sequentially list conditions,	b									_	
	pe.	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dire to (or	ав в попводы	enne utj:								
	xecur and al-trar	xan	that initiated events resulting in death) Last	c Due to (or	as a conseque	ence of):						<u>_</u>		
38760,	ficate be executed physician and sthe burial-transit	dical		► d										
-	tificate g phy as the	ledic												
Box	death certifi e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	me pf pregnar h 2 □ Fetal		∃Ectopic pre	gnancy				23d. Date of deliv	*	
0	0 0	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No		it at time of de		Other (spe					Month	Day Y	'ear
Ρ.	that the de ned by the a detached f	Phy	9 ☐ Unknown  Part II. Other significant conditions			lting in the u	ndarkina co	una aiyan in	. Dort I	220 Did	tohaooo	use contribute to	the cause of de	nath?
or Vital Records,	8 5 9	by	0 .	NCGL	a but not resul	iung in the u	nuenying ca	use given in	irani.			No 3 □ Pro		
Sor	w require been siç should b	Completed	DEMENTI	O .						24a. Wa	e en	24b. Were aut	oney findings a	vailable
Re	The lav	m	Delvie varie							auto perl	opsy ormed/2	prior to co	impletion of ca	
tal	ician: Th certificate ector, pag		25. Was case referred to medical					26	Place of Dea	th (Check only	2 N	o 1 □Yes	2 ∐ No	
<u>&gt;</u>	ysicia is cer direct	To Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inp	atient 2 🗆 E	ER/Outpatier	nt 3 DO	0.1				6 □Other (Speci	ify)	
0	ig Ph ter th		27. Manner of Death  1 ■ Natural 5 ■ Pending	28a. Date of i	Injury Day Year)	28b. Time o Injury	f 28	3c. Injury at Work?		28d. Describe				
<u>.</u>	endir sath. or: At he fur	atic	2 ☐ Accident investigation	n	, ,		М		2 □ No					
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of	injury - At hor , etc. (Specify)	ne, farm, str )	eet, factory,	office		28f. Location City or To	(Street a own, Stat	nd Number or Rui e)	al Route Numb	oer,
	To the Hospital or Attending Physician: within 24 hours after dear. To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Certifier 1 Certifying P	hysician: To the be	est of my know	vledge, deat	h occurred a	at the time	date and place	and due to the	e cause/e	s) and manner as	stated.	
	e Hos 24 h e Fur letely	Medical		miner: On the basi and manner	is of examinati									
	To th within To th comp	Me	29b'. Signature and title of certifier				29c.	License nu	mber			ate signed (Month	-	
				TTENDIN		,	Ì	0006	4533			3/200		
			30. Name and address of person who	completed cause of	of death (Item	23a) (Type,	Print) LL	かいころ	F- MER	- Kow	TERLE	ATTLIC C	in.	
	WE-			AJANI					FRE AV	E. BAI	Timo	ne, MS	2/21	5
Φ.	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 3	2008 32. 86	istrar's Signat	ure	book	9						

			1 - State Registrar 2/27/08 AACO	HEALIH DEPT. C	MH Ce	rtificate of			Reg. No 200	8 08219
	Physici		1. Decedent's Name (First, Middle, La Robert R. Edw	,				2. Date of De Month Februa	ary 22 2	3. Time of Death 2008 7:50A M
-	/Medio Examir		4a. Facility Name (If not institution, give	e street and number)		7.	r Location of Death		4c. County of	Death
			9210 Rolling V  5. Social Security Number 6. S		(In yrs. last birthday	Lanha		8 Date of Birl		e George's  Birthplace (State or Foreign
L	Funeral Director		156-34-6660	<b>X</b> M 2□F	62 Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da Apr 4	1945 N	Country)  Vew York
	/land ow at		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or L	ocation				10d. Inside City Limits
	e Mary Ba-f sh tiffied a	ctor	MarylandPrince	George's	Lanha	m				1 □ Yes 2X No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 9210 Rolling V	iew Dr.		10f. Zip Code 207	06		10g. Citizen of Who	at Country?
	er deat items ? ner mu	uner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Race - Black,	American Indian, White, etc.
036	ours aft ral", or Exami	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 No If Yes, Give Year or Dates: 1	966-72	1 ☐ Yes 🌠 No	Specify:		Specify:	Black
Maryland 21215-0036	n 72 ho "natu edical	To Be Completed	15. Decedent's E (Specify only highest gra	ade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	oation during most of wor	king	16b. Kind of Busin	ness/Industry
212	d withi giene. er than , the M	Somp	Elementary/Secondary (0-12) 12th	College (1-4or 5+) 2yrs		lical Ph			Federal	L Government
and	I be file ntal Hy ed oth	Be (	17. Father's Name (First, Middle, Last George Edwards					ne <i>(First, Middle,</i> ia Will	Maiden Surname)	
aryl	should and Me s mark umatic	۲	19a. Informant's Name/Relationship (		19b. Maili	ng Address (Street				ate, Zip Code)
	1 and 2 Health a em 27 is		Danielle Edwar	ds(Wife)		Rollin	_	Dr. La		1d. 20706
Baltimore,	Pages ont of Herit If Ite		20a. Method of Disposition  1 ☐ Burial 2 【XCremation 3 ☐  4 ☐ Donation 5 ☐ Other (Special		20b. Place of Dispo cemetery, cre	matory or other place remator			20c. Location - Ci	
alti	permit, F Departm Importar any injur		21. Signature of Funeral Service Licer		F	Mame R PAGG	s of Cili on	s Morti	uary, P.	Α.
	205 20	100	Zavery M. /s 23a. Part1. Enter the disease, or com	ease MOUY8.		21 West				21401 Approximate
	Physician.		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each lin.	diale	nua ela	ng, such as cardiac	or respiratory ar	rest,	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	conse uence of):					7.17
	95.0	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a c	consequence of):					
	ecuted and -transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C						
68760,	death certificate be executed e attending physician and ed for use as the burial-transit			Due to (or as a c	consequence oi);					
	ertificat ing phy e as th	Medical	IF FEMALE:							
Ř	attendin for use	cian/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome pf 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin	Fetal death 3	□Ectopic pregnancy □ Other (specify)	<i>y</i>		23d. Date of Month	
J.	at the de by the a	Physician/	9 ☐ Unknown	9□Unknown						
ds,	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions of	ontributing to death but r	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to		ute to the cause of death?  ☐ Probably 4 ☐ Unknown
ecords,	aw req is been 2 shou	plete						24a. Was	an 24b. We	ere autopsy findings available
r	The ate he page	Completed				·		autop perfo 1∐ Yes	rmed? dea	or to completion of cause of ath? ]Yes 2  □ No
VIta	Physician; r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatie	at 3DDOA Oth	26. Place of Dea er: 4 ☐ Nursing H			(Consolidation)
n 0r	ding Phys h. After this funeral di	$\vdash$	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	28b. Time o		y at		dence 6 □Other now injury occurred	
UIVISION	Atten deatl ctor; y the	icati	2 Accident investigation 3 Suicide 6 Could not be		- At home, farm, str		Yes 2 □ No	28f Location (S	Street and Number	or Rural Route Number,
2		Certification:	4 Homicide determined	building, etc. (	(Specify)	,,,		City or Tou		or right right warner,
	To the Hospital or within 24 hours after to the Funeral Dir completely filled in I	edical	29a. Certifier (Check only one)  Certifying Ph 2 Medical Exar	ysician: To the best of r niner: On the basis of ex and manner stated	my knowledge, deat xamination and/or ir d.	h occurred at the tir vestigation, in my c	me, date and place ppinion, death occu	e, and due to the erred at the time,	cause(s) and mann date and place, and	er as stated. d due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	Solo tan	Aug.	29c. Licens	e number		29d. Date signed (i	Month, Day, Year)
)	1XX	V	39 Name and address of person who		th /Item 22a) /T	Print)	21438		Jebrua	ry 26, 2008
	12		MICHAEL J.L	a ENTA M	445 L	) EFENSE	AZ GHWA	m Awa	APOLIS M	1 26, 2008 D 2401
	Sta Registra	•	31. Date filed (Month, Day, Year)  FEB 2 7	32. Registrar's	Signature					
DILI	MH 17 Rev 1/20		ILUNI		U 15 /					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death EDDY Month Day Year JEANNE 3:05 PM MARCH 6,2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL BALTIMORE HARBOR If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 □ M 2 🗹 F MICHIGAN Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No EN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1813 MALTRAVERS RD. 5-A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify 3 ₩idowed 4 Divorced DHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) REPATOR 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Shirler MONTONEY. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State ARDENT CREMATORY 3-11-08 HANCHER, MO. 4 Donation 5 Dother (Specify) 21. Signatur of Foreral Service Licens 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena MD, 21122 Parti. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one sause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MRSA Preumonia Iweek Due to (or as a consequence of) Iweek Pulmonary edeme Sequentially list conditions, from leading 1. In the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 11 days Multiorgan dysfunction
Due to (or as a consequence of): Iweek Septic Shock IF FEMALE:

The law requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760. attending physician for use as the buria ed by the a signed by t been si certificate has completely filled in by the funeral director, To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After it

**Physician** 

/Medical

Examiner

**Funeral** 

Director

an "natural", or items 23a or 28a-f show Medical Examiner must be notified at

traumatic event, the

Pages 1 and 2 should be filed v nent of Health and Mental Hygie int: If item 27 is marked other i

Department of Health Important: If item 27 any injury or other tr

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be ဥ

Examine

Physician/Medical

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Be Completed

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Certification:

Medical

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	account of the programmy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Date of delivery  Month Day Year
Part II. Other significant condition	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ∫nknown
		24a. Was an autopsy performed? prior to completion of cause of performed? 1 ☐ Yes 2 No
25. Was case referred to medical	26. Place of Death (Che	eck only one)
examiner? 1 Tes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No	Describe how injury occurred
3 Suicide 6 Could no 4 Homicide determin	286. Place of injury - At nome, farm, street, factory, office 28f. L	ocation (Street and Number or Rural Route Number, City or Town, State)
	hysician: To the best of my knowledge, death occurred at the time, date and place, and duminer: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.	

29c. License number

RES OUI

29d. Date signed (Month, Day, Year)

6,2008

21225

MARCH

BALTIMURE, MD

State Registrar 31. Date filed (Month, Day, Year) MAR 1. 4 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

3001 S, HANGVER STREET SAYEH HAMZEHZADEH Registrar's Signature

PHYSICIAN

			For State Registrar		State o	of Maryla		artmer <i>rtificat</i>			Mental Hyg	leg. No.	008	08	22
	W 12	E 15	1. Decedent's Name (First,	Middle, Last)	)						2. Date of Dea	ith Day	Year	3. Time o	of Death
	Physici /Medi		ROE	BIN			EAS'	TON			03	06	2008	2015	М
	Examir		4a. Facility Name (If not ins	titution, give	street and nu	mber)		4b. City,	Town, o	r Location of Death	n	4c. Cou	nty of Death		
		44			OCK CAL				MBER				EGANY		
- 61	Funeral		<ol> <li>Social Security Number</li> <li>218-68-4293</li> </ol>	6. Sex	K ]M 2∏_F		rs. last birthday) Yrs.	Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec 14	Year)	9. Birth Cou	place (State ntry) MD	or Foreig
	Director		Usual Residence of Decede			51					Dec 14	, 1950	,	טועו	-
	Maryland  -f show filed at	tor	10a. State 10b. C	ounty Allega	ny	10c.	City, Town or Lo	Sava	ge					10d. Inside 0 1 ∐Yes	City Limits
	th with the 23a or 28a sst be not	Funeral Director	10e. Street and Number	elville l	Road			10f. Zip	p Code	21545		10g. Citizen	of What Cou	ntry?	
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland t of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married ※ 3 □ Widowed 4 □ Div	] Married	12. Was Dec Armed Fo 1 ☐ Yes If Yes, Gi Year or D	edent Ever in orces? 2 📉 No ve oates:		Was Dece If Yes, spe 1 ☐ Yes		lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	1	Race - Amen Black, White, ec <i>ify:</i> <b>wh</b>		
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b	al Hygi t other	e B	17. Father's Name (First, M	,							ne (First, Middle,	Maiden Sur	name)		
ylai	should be and Mental s marked o	To Be	Paul Lec	hliter						Gloria					
, Maryland	1 and 2 sho Health and Hem 27 Is m		19a. Informant's Name/Rel  Douglas Ea	. ,		nusbar		ng Address 212 B	s (Street Barre	and Number or Ru Iville Roa	ural Route Numbe d Mt. S	r, City or To	ewn, State, Zi <sub>l</sub> D	n Code) 1D 215	545
Baltimore,	Pages 1 and of He net of He net: If Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Creme 4 ☐ Donation 5 ☐ Ot		Removal from	Ctoto	b. Place of Disponentery, cre carpelli Fu	matory or (	other plac		Date 3/9/2008		on - City or T saptow		MD
Balti	permit. Page Department of Important: If any injury or once.		21. Signatur 1 Fureral Se		97/1.		2			ss of Facility Ili Funeral Ho ginia Avenue		nd MD 3	21502		
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	Physician		Immediate Cause (Final disease or condition	. List only of	0								Onset and	Death	
	/Medical		resulting in death)	-	Due to		sequence of):	VIIC							
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	ficate be executed physician and sthe burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		s		as a consequence of);								
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.O. Box 6	death certi e attending d for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 □ Yes 2 □ No 9 □ Unknown		⊒Ectopic p ⊒ Other (s		y		23d.	. Date of deliv	very Day	Year			
Δ.	res that signed by be deta		Part II. Other significant co	onditions co	ntributing to d	leath but not	resulting in the u	ınderlying o	cause giv	ren in Part I.	23e. Did to	bacco use	contribute to	the cause of	death?
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or Vital Records,	ie law requires that the has been signed by th ge 2 should be detache	Completed	Morb	rd	010e	situ	<u> </u>				24a. Was a autop perfor	sy	4b. Were aut prior to co	opsy findings ompletion of	s available cause of
a	ician: The certificate ha ector, page		OF Man once externed to	adical T						00 Pt	1□ Yes	2 No	1 ☐ Yes	2 No	
N.		o Be	25. Was case referred to mexaminer? 1 ☐ Yes 2 No	-	lospital: 1	Inpatient 2	2 ☐ ER/Outpatie	nt 3□ D	OA Oth	er.	ath (Check only or		Othor (C	i6.1	
	ling After une		27. Manner of Peath	Pending nvestigation	28a. Date	<b>.</b>	28b. Time of		28c. Injui Wor		dome 5 ☐ Resid		. , ,	119)	
Division	I or Attending after death. Director: After I in by the fune	ertification:	3□ Suicide 6□0	Could not be determined	28e. Place build	e of injury - A ling, etc. (Sp	At home, farm, st ecify)			103 Z [ NO	28f. Location (S City or Tow	Street and No rn, State)	umber or Rui	ra <i>l R</i> oute Nu	mber,

Medical Certification

State

To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral

29a. Certifier (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29b. Signature and title of cert 14ACA

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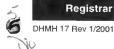
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900

31. Date filed (Month, Day, Year) MAR 1 4

32. Registrar's Signature



08-01643 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Delores J. Floyd 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month Day February 26, 2008 1026 hrs **Medical Examiner** DELORES JOAN FLOYD 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Linder 1 Year If Under 24Hrs **Funeral** Hours Director Country)MARYLAND 219-38-0074 1 M 2 XF 66 08/02/1941 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Yes 2 X No MARYLAND OUEEN ANNE'S STEVENSVILLE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 905 BAYSIDE DRIVE 21666 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married 2 X Married 2 X No Yes 5 1 Yes 2 X No specify: WHITE Specify: after If Yes, Give Year Widowed 4 Divorced \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 72 1 Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygeine. Important: If item 27 is marked other than injury or other traumatic event. the Medica TEACHING ASSISTANT EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DELORES ELAINE SOHN THEODORE HENRY RIPKE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BAYSIDE DRIVE, STEVENSVILLE, MD 21666 CHARLES T. FLOYD/HUSBAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 3/1/2008 SECRETARY, MARYLAND OUR LADY OF GOOD COUNSEL Donation 5 Other Specify 22. Name and Address of Facility
ZELLER FUNERAL HOME STPNEW MARKET, MD 21. Sign turn of Funeral Service 21631 art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions ner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED signed by the attending physician. P.O. Box 68760, 23d. Date of delivery IE EEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has performed? 2 No ✓ Yes 2 1 🗸 Yes 26. Place of Death (Check only one 25. Was case referred to medica Be examiner? Hospital: Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this 1 V Yes After 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day, Year Certification 1 V Natural Yes 2 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc.

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Director: d in by the f t 24 hours a within 2

Could not be Suicide determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier

29c. License number O.C.M.E

29d. Date signed (Month, Day, Year) February 27, 2008

or Town, State)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner Carol Allan, MD

111 Penn Street, Baltimore, MD 21201

State Registrar

Medical

31. Date filed (Month, Day, Year) FEB 2 9 2008



8-0428 ence of Decedent  10b. County  10b. County  10b. County  11c. C	Montgon  12. Was De Armed F  1   Yes, C Year or College  Last)  Le  nip (Type. Print)	7. Age (In yrs. 64  10c. Cli nery  cedent Ever in U corces? 2 2000	Yrs.  ty, Town or Lo  Si .S. 13. 1  16a. Decec	Sill  If Under 1 Yr  Months December 209  Was Decedent If Yes, specify 0  UYes 2 3  dent's Usual Ocklind of work do NOT use re	ring  O1  of Hispanic Origin: Cuban, Mexican, Pi No Specify:	eath  ng  Hrs. 8. Date of Bi (Month, Di Aug. 2	Day 27 4c. Could have a ry 27 4c. Could have	9. Birthc Cour Chi	ntgomery place (State or Foreign ntry) 1e 10d. Inside City Limits 1  Yes 2 No ntry? ritain can Indian, etc.
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of Disposition ial 2 <b>X</b> Cremation ation 5 ☐ Other ( <i>Sp</i>	Le/Brothe		19b. Mailir	ng Address (Str	eet and Number o	r Rural Route Numb	er, City or To	own, State, Zip	Code)
ial 2 <b>⊠</b> Cremation ation 5 ☐ Other ( <i>S</i> <sub>E</sub>						d, Charlo			
_	3 ☐Removal from	n State	cemetery, crer	sition (Name o matory or other	place) I	Feb. 28,	20c. Locati	ion - City or To	own, State
		Me			ematory	2008	Alexa	ndria,	Virginia
e of Funeral Service L	4/					ins Funer			
Enter the disease, or	complications that	caused the deat						r Spri	ng, MD 2090 Approximate Interval Between
or heart failure. List of Cause (Final ondition death) list conditions, g to immediate	a. Ac Due to	eute Str o (or as a conseq tastatio	uence of):	Cancer					Onset and Death
list conditions, g to immediate in Underlying ase or injury events leath) Last	c Due to	o (or as a conseq	uence of):						
	1□Live 4□Preg		al death 3	⊒Ectopic pregna ] Other <i>(specif</i> )			23d.	. Date of delive Month	ery Day Year
-	ens contributing to	death but not res	ulting in the ur	nderlying cause	given in Part I.				
						- 2			
						—   auto	psy prmed?	4b. Were auto prior to con death?	ppsy findings available mpletion of cause of
						1□ Yes	XX No	1 ☐ Yes	2 □ No
r?	Hospital:	Therefore A -			Other:				
	28a. Date	e of Injury	28b. Time of	" 3D DOY	4 LI Nursin				<u>y)</u>
	d   '	nth, Day Year)	Injury						
datarmi	ined   286. Plac	ce of injury - At ho ding, etc. (Specif	ome, farm, str	eet, factory, off	ice	28f. Location ( City or To	Street and N wn, State)	umber or Rura	ıl Route Number,
r 11 Certifying only 2 Medical E	Examiner: On the	basis of examina	wledge, death	h occurred at th vestigation, in r	e time, date and p ny opinion, death o	lace, and due to the occurred at the time	cause(s) and date and pla	d manner as s ace, and due to	tated. o the cause(s)
re and title of certifier	$\alpha$								
()~ /c	Cahm	ani	4.	1	066372		Februa	ary 27,	2008
	who completed cau	use of death (Iten	n 23a) (Type,						
d address of person v	MD 15	00 Fores	st Gler	n Road,	Silver S	Spring. Mi	2091	0	
	tension  Re referred to medical referred to me	r significant conditions contributing to tension  tension	se referred to medical    Standard   Standa	se referred to medical  **EXENO  **Independence of Death investigation investigation investigation investigation edge determined  **The Certifying Physician: To the best of my knowledge, death and manner stated.  **The Certifier of Cauld not be determined investigation and manner stated.  **The Certifier of Cauld not be determined investigation and manner stated.  **The Certifier of Cauld not be determined investigation and manner stated.  **The Certifier of Cauld not be determined investigation and manner stated.  **The Certifier of Cauld not be determined investigation and manner stated.  **The Certifier of Cauld not be determined investigation and manner stated.  **The Certifier of Cauld not be death (Item 23a) (Type, and address of person who completed cause of death (Item 23a) (Type, and address of person who completed cause of death (Item 23a) (Type, and address of person who completed cause of death (Item 23a) (Type, and address of person who completed cause of death (Item 23a) (Type, and address of person who completed cause of death (Item 23a) (Type, and address of person who completed cause of death (Item 23a) (Type, and address of person who completed cause of death (Item 23a) (Type, and address of person who completed cause of death (Item 23a) (Type, and address of person who completed cause of death (Item 23a) (Type, and address of person who completed cause of death (Item 23a) (Type, and address of person who completed cause of death (Item 23a) (Type, and address of person who completed cause of death (Item 23a) (Type, and address of person who completed cause of death (Item 23a) (Type, and address of person who completed cause of death (Item 23a) (Type, and address of person who completed cause of death (Item 23a) (Type, and address of person who completed cause of death (Item 23a) (Type, and address of person who completed cause of death (Item 23a) (Type, and address of person who completed cause of death (Item 23a) (Type, and address of person who completed cause of death (Item 23a) (Type, and	See referred to medical ry   Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA	See referred to medical ry   See referred t	See referred to medical result   See referred to medical result	Security of the person who completed cause of death (Item 23a) (Type, Print)	Security ing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as as only 2   Medical Examiner: On the basis of examinantion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as as only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as as only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as as only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date on place, and due to the cause(s) and manner as a some only a control of the date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date on place, and due to the cause(s) and manner stated.  The certifician occurred at the time, date on place, and due to the cause(s) and manner as a some occurred at the time, date on place, and due to the cause(s) and manner stated.  The certifician

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Mont **Physician** 11:48A M 2008 Frances Garry March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 206 N. Main St. Woodsboro Frederick If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. Months Hours 1 ☐ M 2 🔀 F Nov. 21, 214-46-6415 60 1947 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Director Texas San Antonio Bexar 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? a or ms 23a 111 Adams St 78210 U.S.A. Funeral "natural", or items adical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed by 3 Widowed 4 Divorced White Year or Dates ed other than "natu 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) switchman/ yard master railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jane Cain Joseph J. Garry P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Kalins/ mother 703 Jason Dr. Lady Lake, FL 32159 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any Injury or c 1 ☐ Burial 2 Cremation 3 ☐ Removal from State All County Cremation 3/8/2008 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 22. Name and Address of Facility HartzlerFuneral Home 21. Sign of Fyneral Service Lice 404 S. Main St. Woodsboro, MD 21798 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final **Physician** heroscleretio disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of) i any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and -trans Due to (or as a consequence of): burial-t P.O. Box 68760, physician the buria by Physician/Medical e attending p d for use as as IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant et time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 ☐ Other (specify) signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 □Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has page 2 autopsy performed certificate 1∐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) brother's xaminer? Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2□ No 6 Other (Specify) residence 1 🔲 Inpatient 2 ER/Outpatient 3□ DQA Certification: To this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🛮 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certiffe

31. Date filed (Month, Day, Year)

MAR 1 4 2008

DHMH 17 Rev 1/2001

**ORIGINAL** 

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 08225

		1- For State Registrar		Certifica	ate of L	Death			Re	g. No.	UU	0022
Physicia	an/	1. Decedent's Name (First, Midd		-				1	Date of Death	Day Yea		3. Time of Death
edical Exami	ner	Paul John Hayd  4a. Facility Name (if not institution)			146	. City, Town, or	Logation	1	March 4, 2	008 4c. County o		1905 hrs
		7890 Huguenot Cour	=			Severn	Location o	Death		Anne Ar		
Funeral		5. Social Security Number	6. Sex 7. Age (I	n yrs. last birt	thday)	If Under 1 Yea	If Under	r 24Hrs.	8. Date of Birtl	h (MM/DD/YYYY		
Director		218-11-5269	1 M 2 F	24	Yrs.	Months Day	's Hours	Min.	8/28	/1983	Foreign Cour	
	ı	Usual Residence of Decedent						<u> </u>				
w any		10a. State 10b. County		c. City, Town								10d. Inside City Limits  1 Yes 2 X No
·land -f sho once,	ğ		ne Arundel		Sever				Lan	678		
r 28a	Director	10e. Street and Number	-			10f. Zip Code			10	g. Citizen of Wh		ry r
ith the		7890 Huguenot	12. Was Decedent Ev	er in II S	13 Was	Decedent of Hi	1144	in? (Spec	ify Ves or No-		USA - America	an Indian, Black,
eath w items ust be	Funeral	1 Never Married 2 N				s, specify Cuba					e, etc.	
after d	by Fi	3 Widowed 4 Di	ivorced of Peter	NO	1 \	res 2 X No	specify:			Specify:		White
hours	8		ecify only highest grade comple			Usual Occupa				16b. Kind of Bu	isiness/Inc	dustry
36 in 72 l han ", lical F	Completed	Elementary/Secondary (0-12)	) College (1-4 or 5+)	1	_	tudent				Educa	tion	
d with	mo:	17. Father's Name (First, Middle	e. Last)		31	Ludent	18. Mother	's Name (F	irst, Middle, M	Maiden Surname		
215 be file stal Hy ked o	Be (	Paul K. Hayden					Patr:	icia	Ouelle	tte		
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Higgiene Important: If them 27 is marked other than "matural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	19a. Informant's Name/Relation								ber, City or Tow		Zip Code)
MC nd 2 sl alth ar m 27		Paul K. Hayden  20a. Method of Disposition	rather			on (Name of ce			Date	D 21144		oum State
Baltimore, Permit. Pages 1 an Department of Hea Important: If Iter njury or other tra		1 X Burial 2 Crematic	on 3 Removal from State	cremat	tory or othe	er place)	sinetery,				-	
Baltimo permit. Page Department o Important: injury or otl		4 Donation 5 Other S		Cedar	r Hill		o of Facility			Suitla uneral		
Bal Permi Depar Impo injur		21 pature of Funeral Service	e Licensee							s, MD 2		, I.A.
Physician	-	23a. Part I. Enter the disease, o		e death. Do n								Approximate Interval Between Onset and
/Medical	K (4	failure. List only one cause Immediate Cause (Final diseas	0 1 1	zolpide	em into	xication						Death
Adillillei		or condition resulting in death)										
	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	ence of):							_	
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		IF FEMALE: 23b. Was decedent pregnant in	23c. If yes, outcome							23d. Date o	_	eu Year
30x 68 death certifi te attending I for use as	Physician	past 12 months?	1 Live birth 4 Pregnant at tim		_ =	ideath 3 er (Specify)	Ectopic	c pregnanc	Ŋ	Month	D.	ay Year
Box e death c the atten ed for us	hysi	1 Yes 2 No 9 U	nknown g Unknown			. (		. s. A.III:				
P.O. Box 68' that the death certifine ned by the attending detached for use as	by P	Part II. Other significant cond	litions contributing to death b	ut not resultir	ng in the un	derlying cause	given in Pa	art I.				he cause of death?  ably 4 🗸 Unknown
— & 'go s		. —							24a. Was			opsy findings available
Sorce aw rec nas be 2 shoo	Completed	II ————							autop			ompletion of cause of
tal Rectan: The certificate ector, page	S								1 ✔ Yes		1 🗸 Ye	s 2 No
of Vital Records, g Physician: The law requir the centificate has been so neral director, page 2 should t	Be	25. Was case referred to medic examiner?	Hospital: 1 Inpatient	2 ED/C	Outpatient	·	Other			Residence 6	✓ Other	Scene
of V ig Phys fter thi	. To	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b.	Time of In		ury at Work			how injury occur		
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pital ours al	Certification:	4 Homicide det	termined (Specify)Found	at home	9			178	or Town, S 890 Hugu	enot Ct.	Sever	n,MD
Division  To the Hospital or Attenwihin 24 hours after death To the Funeral Director:		29a. Certifier 1 Certifying I	Physician: To the best of my kaminer:On the basis of examin	nowledge, de	eath occurre	ed at the time,	date and pla on, death oc	ace, and d	ue to the caus	se(s) and manne and place, and	er as state	ed. e cause(s)
To the within To the comple	Medical	29b. Signature and title of certif	and manner stated.				se number					nth, Day, Year)
	_	Pat an	mai Pal	0.1	\w	0.0	.M.E.			March 5, 2		
2.00	W	30. Name and address of person	on who completed cause of dea	th (Item 23a)								
Ne		Patricia Aronica-Polla			niner	111 Penn S	Street, Ba	altimore	, MD 2120	1		
S Regis	tate trar	31. Date filed (Month, Day, Year	32. Registrar's	Signature	1	ande						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend line 20b per fd State of Maryland / Department of Health and Mental Hygiene ·aaco hlth dept 02/28/08 dlw 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Day Lorren E. Hackett 22 2008 February 12:36p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Annapolis Arunde1 If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F 70 Yrs. 578-48-9013 9 May Director 1937 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notifled at MarylandPrince George's Bowie 1 ☐Yes 2X No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2911 November Ct. 20716 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Black þ 3 Widowed 4 Divorced ear or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ייייי איוחווי. ביים Mental Hygiene. ז בז is marked other than "יי זי traumatic event" ביי Elementary/Secondary (0-12) College (1-4or 5+) Pastor 12th 4yrs Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Health and Mental Alonzo Montgomery Hackett Leana Claggett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health at
Important: If item 27 is
any injury or other trau 2911 November Ct. Bowie, Md. 20716 Vancie A. Hackett(Wife) 20b+Place of Disposition (Nation of Lincoln 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial 2-29-08 4 Donation 5 Other (Specify) Annapolis, Md. Montage Reaction of Collisions Mortuary, P.A. 21. Signature of Funeral Service Licensee Jarry 821 West St. Annapolis, Md. 21401 1. Treese mooy 83 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, that he admy to him date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of has e 2 autopsy certificate has irector, page 2 1∐ Yes Hospital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes (2) 1 Inpatient 2 2 ER/Outpatient 3 DOA this funeral 27 Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No after death.

| Director: /
d in by the f 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my howledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier he basis of emanner state (Check only one) 2 Medical Examiner: On nination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and of certific Ause of death (Item 23a) (Type, Pri 30. Name and address of person

Registra

31. Date filed (Month, Day, Year)

Registrar's Signature 32

FEB 27 2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Feb 4 25 PM 2008 DVNOC Howard 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore niversity Mary 8. Date of Birth (Month, Day, Year) MARCH 8 1966 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Days 1 ☐ M 2 🖫 F NORTH CAROLINA 242-39-0304 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 17∏Yes 2 No MD PRINCE GEORGE'S BOWIE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20716 USA 15800 ANTHONY WAY 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married BLACK 1 ☐ Yes 2 🗓 No Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE LOAN OFFICER 2 YRS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BERTHA MCMILLIAN WILLIAM OAKMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15800 ANTHONY WAY BOWIE, MARYLAND 20716 GARVIN HOWARD/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State SUITLAND, MARYLAND 3/1/2008 CEDAR HILL CEMETERY 4 □ Donation 5 □ Other (Specify) J. B. JENKINS FUNERAL HOME e of Funeral Service License 22. Name and Address of Facility 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) muumonia days Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or, Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an

Physician /Medical **Examiner** 

and

the attending physician

**Physician** 

/Medical

Examiner

Director

Funeral

à

Completed

Be

2

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumafte event, the Medical Examiner must be notified at any Injury or other traumafte event, the Medical Examiner must be notified at

3altimore, Maryland 21215-0036

Examiner Physician/Medical ģ Completed Be

The law requires that the death certificate be executed

or Attending Physician:

After this

Medical

State

Division or Vital Records, P.O. Box 68760,

burial-trar the is been signed by the should be detached funeral director, Certification: To To the Hospita. .
within 24 hours after deatn.
To the Funeral Director: AF

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

autopsy 2 □ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

_	Je ies
	26. Place of Death (Check only o
DOA	Other: 4 Nursing Home 5 Resid

dence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

2 Accident

4 Homicide

3 Suicide

1 Naturai

1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

3□[

2 ER/Outpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

29d. Date signed (Month, Day, Year) 2008

30. Name and Iddress of person who completed cause of death (Item 23a) (Type, Print)

Greene St Balhman, MD 2120

Hospital: 1 Inpatient

28a. Date of Injury (Month, Day Year)

31. Date filed (Month, Day, MAR 0 3 2008 32. Registrar's Signa

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month February28 2008 10:12 AM Theresa F. Haines 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Worcester Berlin Berlin Nursing Home If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number (Month, Day, Year) 6/13/1928 Months Days Hours 1 □ M 2 🗓 F 79 NY 062-22-7802 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21811 9848 Holly Grove Rd. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John O'Sullivan <u>Theresa Sullivan</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9848 Holly Grove Rd., Berlin, MD 21811 Donald Haines / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 3/3/2008 Berlin. MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Juneral Service Licent 108 William St., Berlin. MD 21811 Point. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final tews disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

"natural", or items 23a or 28a-f show Idical Examiner must be notified at

the Medical

7 Is marked other than traumatic event, the Me and 2 should be filed withi ealth and Mental Hygiene.

permit. Pages 1 and 2 shoul Department of Health and M Important: If Item 27 Is marl any injury or other traumationce.

Funeral Director

Completed by

Be

MD

filed within 72 hours after death with the Maryland

21215-0036

Baltimore, Maryland

Box 68760,

P.O.

Division or Vital Records,

Theresa

HAnies

Examine physician and s the burial-trans Physician/Medical SS attending nse ρ the a signed by t Completed by peen

has certificate funeral director, this After

the death certificate be executed To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A filled in by the

Be

P

Certification:

Medical

DH 20

DHMH 17 Rev 1/2001

State Registrar

Vielwoo 31. Date filed (Month, Day, Year)

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certile

6 Could not be determined

32. Registrar's Signature

and manner stated

ddress of person who completed cause of death (Item 23a) (Type, Print)

Coastel Hybry Fewerk Foles, Pe 19944 209

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Scartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Yea MAR 0 3 2008

NICHOLAS DEMONACO M.D. 8926 WOODYARD ROAD # 201 CLINTON, MARYLAND 20735

32. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🗹 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Hawkins Ella E. 630PM EBRUATY 27 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Lanham Doctor's Comunity Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2**X**F Director 579-52-6566 Washington, D.C. October 23, 1939 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Marylar feath and Mental Hygiene.

m 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at Maryland Lanham Prince George's Director 1XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 U.S.A. 9115 Alcona Street Funeral 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 XXVo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: þ 3XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Security Exchange Commission Elementary/Secondary (0-12) College (1-4or 5+) (Federal Government) Administrative Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William O. Thomas Elizabeth Stewart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9115 Alcona Street Lanham, Maryland 20706 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Mrs. Toni E. Morgan (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State March 5, 2008 Maryland National Park | Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rollins Fureral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019 23a. Port. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical e to (or as a consequence of) Examiner Se quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Il-transit The law requires that the death certificate be executed Due to (or as a consequence of): ending physician a use as the burial-.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atten for u 1 Live birth 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9□Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an 1 Division or Vital Yes director, Be 25. Was case referrexaminer? to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 3□ DOA 1 Yes 1 🔲 Inpatient 2 R/Outpatient Certification: To this After this funeral of 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Man or of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO. 3118 Good Luck Rd. , Carham, 31. Date filed (Month, Day, Year) State MAR 0 3 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month MARCH 08, 2008 BERNARD 0615 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** WMHS-Memorial Campus CUMBERLAND ALLEGANY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y May 13, 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Hours МD 217-28-0683 Director 75 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Allegany Cumberland MD Director 1 ¥Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14135 Hazen Road NE 21502 USA Completed by Funeral 12. Was Decedent Ever in U.S.
Aspred Forces?
1 ☐ Yes ≥ ☐ No
If Yes, Give
Year or Dates: 1954-56 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pittsburgh Plate Ind. Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary (McGuire) Hare G. Bernard Hare P Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code).

14135 Hazen Road NE Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print) Jeanora Hare wife 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sunset Memorial Park Date permit. Pages Department of Important: If It any injury or o 3/11/2008 MD Cumberland 4 □ Donation 5 □ Other (Specify) 21. Signature Fuyeral Service Liven ee 22. Name Scamen Punellal Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final 1 -1-6 Physician/Medical Examiner

**Physician** /Medical **Examiner** 

Baltimore, Maryland 21215-0036

requires that the death certificate be executed sician and burial-trans attending phase as t has been signed by the a person of the signed by the signed be detached be detached the signed between the s page certificate To the Hospital or Attending Physician: After th funeral

Division or Vital Records, P.O. Box 68760,

1	disease or condition	a Misactan	ial	bleed		1 0	94
	resulting in death)	Due to (or as a conseq	uence of):				J.
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b					
ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	il death 3 □Ectopic			23d. Date of delivery  Month Day	Year
ed by Ph	Part II. Other significant conditions of	contributing to death but not res	ulting in the underlying	g cause given in Part I.		co use contribute to the cause of	1
Complet					24a. Was an autopsy performed	24b. Were autopsy finding prior to completion of death?  No 1 Yes 2 No	s available cause of
Be	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)		
To E	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 panpatient 2 □	ER/Outpatient 3	DOA Other: 4 Nursing I	Home 5 Residence	6 □Other (Specify)	
	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
Medical Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At he building, etc. (Special	ome, farm, street, fact fy)	ory, office	28f. Location (Street City or Town, St	and Number or Rural Route N ate)	umber,
dical (		nysician: To the best of my knominer: On the basis of examination and manner stated.					e(s)
Me	29b. Signature and title of certifier	A)	1	29c. License number	29d.	Date signed (Month, Day, Year	)

29c. License number

Kent Ave. Cumberland, MD. 21502

State Registrar Afa Ahma 31. Date file (Month, Day, Year)

Ahmad

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3

within 24 hours after death

To the Funeral Director:
completely filled in by the

DHMH 17 Rev 1/2001

625

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 8 Month MARCH 2008<sup>a</sup> NANCY 11:04 A M **Physician** HAWKINS LEE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth Social Security Number 217-42-9078 6. Sex **Funeral** September 11, 1945 Mary land 1 M 2 X F 62 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show ural", or Items 23a or 28a-f shov Examiner must be notifled at 1 X Yes 2 ☐ No Frederick Frederick Maryland Director the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21701 206 East 6th Street filed within 72 hours after death ' Hygiene, other than "natural", or Items 23 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 2 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Me I al Elementary/Secondary (0-12) College (1-4or 5+) Education Custodian permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien Important: If Item 27 is marked other than any injury or other treasment. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Staub William Stoner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 64 Moser Road, Thurmont, Maryland 21788 Daughter Cheryl Ann Reynolds / 20b. Place of Disposition (Name of cemetery, crematory or other place) March 20c. Location - City or Town, State 20a. Method of Disposition Smithsburg, Maryland 1 ☐ Burial 2 【\*\*Cremation 3 ☐ Removal from State Smithsburg Crematory 16, 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. Funeral. Home 21. Signature of Funeral Service License 106 East Church Street, Frederick, Maryland 21701 M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a ld be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No s certificate has be inector, page 2 s 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: Hospital: 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28d. Describe how injury occurred Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of within 24 hours after death.

To the Funeral Director: After of the funeral completely filled in by the funeral completely filled in the f Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 2 Medica and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifi March 8, 2008 D-62471

State Registrar

31. Date filed (Month, Day, Year) MAR 14

Ghulam Abbas MD



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

**ORIGINAL** 

400 West Seventh Street, Frederick, Maryland 21701

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1:15 a M February 27, 2008 Joseph Pau1 Hagan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bedford Court Nursing\_Home Spring
If Under 24 Hrs Silver Montgomery 8. Date of Birth (Month, Day, Year) June 5, 1915 last birthday 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days 1 € M 2 🗆 F Months Hours Min. Pennsylvania 197-05-1316 92 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Mary land Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3701 International Drive, #109 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1942-46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) filed withi Hygiene. Adjudicator Federal Government permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 Is marked other I any Injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Hagan Hilda Brady ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne K. Stratton/Daughter 4623 Edgefield Road, Bethesda, MD 20814 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 1, 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2008 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 2 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed and Due to (or as a consequence of): physician as Records, P.O. Box 68760 Physician/Medical as attending IF FEMALE: use a 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown þ signed b I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown as been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has ' autopsy performed page certificate 1 Yes Division or Vital 2k No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No <sup>o</sup>L 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: To the Hospital or Attending 5 ☐ Pending investigation Injury 1 Natural within 24 hours area co.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D38457 February 28, 2008 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nakul Goyal MD 3801 International Drive, #211, Silver Spring, MD 20906 31. Date filed (Month, Day, Year) 329 Registrar's Signature State FEB 2 9 2008

DHMH 17 Rev 1/2001

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 02/28/08 2:00 A<sup>M</sup> Elizabeth Alice Hunter-Schroeder /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Joseph Ritchie Hospice Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🕅 F Director 456-56-1088 68 Aug 23, 1939 Texas Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 77 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director VA Fairfax Alexandria 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5938 Bush Hill Road 22310 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after lealth and Mental Hygiene. m 27 is marked other than "natural", or ite 1 Yes 2 Y If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Howard H. Davenport Mildred Van Ummerson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Timothy D. Blanchard/son 8610 Lancaster Drive Bethesda, MD 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory : 03/01/08 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service Licens Going Home Cremation Service

MO1251 Beverly L. Heckrotte, P.A. (

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death Bone Wetsstases Immediate Cause (Final Concer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusity (or as a consequence or, Examine burial-transit and Due to (or as a consequence of): physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregrant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 4□Pregnant at time of death P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Miknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autonsy perforr 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 After this 27. Manyor of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: al or Attending F s after death. Division 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attence within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and D06030 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beltmane MD 21210+303 9 W. Lake Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 03 2008 Registrar

DHMH 17 Rev 1/2001

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Schroe

			for State Registrar	State of Ma	arylani	-	rtificate of		wernar n	ygierie Reg. No.	2008	08235
	Physici	an	Decedent's Name (First, Middle, I     Ruth V.	Holter		·			2. Date of D Month	eath Day	' Year	3. Time of Death
	/Medi	cal	4a. Facility Name (If not institution, g				4b. City, Town, o	r Location of Dea	Februa		2008 County of Death	8:00
	Examir	ier	Alice Byrd Tawes				Crisf			1	Somerset	
	Funeral		,	. Sex 7. Ag	e (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		irth Day, Year)	9. Birthp	place (State or Foreign
	Director		215-28-5312 Usual Residence of Decedent		90	Yrs.			7/6/		Mar	yland
	/land ow at		10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	a-fsh ifled	ctor	Maryland Wicom	ico	Fr	ruitla	nd					1 □ Yes 2 ▼No
	ith the or 28 oe not	Dire	10e. Street and Number				10f. Zip Code			10g. Citi:	zen of What Cour	ntry?
	ath w s 23a nust t	Funeral Director	834 Sharps Poin				2182			US		1-4:
	ter de Items	nne	11. Marital Status  1 □ Never Married 2 X Married	12. Was Decedent i Armed Forces? 1 □ Yes 2 🛣		5. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? ( an, Mexican, Pue	Specify Yes or Nerto Rican, etc.)	10-	<ol> <li>Race - Americ Black, White,</li> </ol>	
336	urs af al", or xami	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🛣 No	Specify:			Specify: whi	ite
- -	72 hor	Completed by	15. Decedent's (Specify only highest of	Education		16a. Dece	dent's Usual Occup	ation	orkina	16b. Kii	nd of Business/In	dustry
2	ithin ne.	Jd L	Elementary/Secondary (0-12)	College (1-4or 5	5+)		kind of work done DO NOT use retire	d)	Jg	7-		
2	filed within 72 hours after death with the Maryland Hygiene. uther than "hatural", or Items 23a or 28a-f show ont, the Medkel Examiner must be notifled at	CO	17. Father's Name (First, Middle, La	est)		HOILE	emaker	18. Mother's N	ame (First, Middi		omestic Surname)	
aŭ	lould be I Mental narked o	To Be	William Leitch	,					B. Voss		,	
Maryland 21215-0036	등 의 <b>대 대</b>	-	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street	and Number or I	Rural Route Num	ber, City o	r Town, State, Zip	Code)
	1 and 2 Health a tem 27 Is		Walter J. Holter	:/husband			Sharps F					
Baltimore,	Pages 1 nent of H ant: If iter ary or oth		20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3	☐Removal from State			sition (Name of matory or other pla	1 - 1	Date		cation - City or To	
Ħ,	t. Partmen rtant:		4 □ Donation 5 □ Other (Spe		Sha		nt Cemete		28/08		isbury,	
Ba	permit. Page Department of Important: If any Injury of once.		21. Signature of Funoral Service Lice	la d	FSF	o 1	Olloway Ol Snow	Funeral	Home Pr	ofess	sional As	sociation 04
Ė			23a. Part1. Enter the disease, or co	omplications that caused	the death			***			2100	Approximate Interval Between
	Physician		shock, or heart failure. List or Immediate Cause (Final disease or condition	ly one cause on each in	ne.		ASCU	D .				Onset and Death
10	/Medical		resulting in death)	Due to (or as	a consequ	ence of):						
	Examiner	<u>.</u>	Sequentially list conditions,	b Due to (or as	2 coneggi	ionco of):						
	rted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dreade or Injury that initiated events	Due to (or as	a consequ	ience orj.						
ď.	execun and ial-tra	Еха	resulting in death) Last	c. Due to (or as	a consequ	uence of):						
68760,	tificate be executed g physician and as the burial-transit	edical		d								
		100	IF FEMALE:							- 1		
. Box	ath coatherd	Physician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3	☐Ectopic pregnanc☐Other (specify) _	у		2	23d. Date of delive Month	ery Day Year
Ö	the de	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	t time or de	aui SL		11111				
<u>α</u>	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	by Pt	Part II. Other significant conditions	s contributing to death b	ut not resu	ılting in the u	nderlying cause giv	en in Part I.	23e. Did	l tobacco u	se contribute to t	he cause of death?
ord	equire en sig ould b	ed b							_ 1[	Yes 2	XNo 3□ Prot	oably 4 ☐ Unknown
Records,	law re as be 2 sho	Completed						a	24a. Wa	s an opsy		psy findings available mpletion of cause of
<u>~</u>	10 22	Con							per 1□ Yes	formed? 2 No	death? 1 ☐ Yes	21 No
Vita	Physician: The law r this certificate has b ral director, page 2 sl	Be	25. Was case referred to medical examiner?	Hospital:			oth		eath (Check only			
Ö	g Phys er this eral di	7: To	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatie	ıry	ER/Outpatier 28b. Time o	f 28c. Inju	y at	Home 5 ☐ Re 28d. Describe		6 □Other (Special occurred)	fy)
o	Attending Prdeath. ector: After by the funer	atior	1 Avatural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Daj	y Year)	Injury	M 1	rk? Yes 2∐No				
Division or	l or Attendatter death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At ho	me, farm, str	eet, factory, office			(Street and	d Number or Rura	al Route Number,
Ω	pital or ours afte eral Dir filled in		20a Cortifiar 4 M Contif 1	Physician To the feet	of my limit	uladea ==-	h oppured state "	mo dete e- + - +	no and due to it	o oeu/-1	and man-	tatad
	To the Hospital or Attending Physician; within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best caminer: On the basis o and manner sta	of examinat	wieage, aeat tion and/or in	vestigation, in my	me, date and pla opinion, death oc	ce, and due to the curred at the time	e cause(s) e, date and	and manner as s I place, and due t	o the cause(s)
	To the within 3	Me	29b. Signature and title of certifier	and mainter ou			29c. Licens	e number	-	29d. Dat	e signed (Month,	Day, Year)
	nu n		N	N	0,		D	4.809	8	0	2/25/2	2008

Registrar

DHMH 17 Rev 1/2001

State

201 Hall Highway, Crisfield, MD 21817

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Megistrar's Signature

Dr. Vijay Karumbunathan

31. Date filed (Month, Day, Year) FEB 2 8 2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Item Registrar	State of Mary 21 per fh,go	land / Depa 377,03/1	artment of H	Health and Death	Mental Hy	giene Reg. No.	2008	082	236
	01		1. Decedent's Name (First, Middle, Las	st)				2. Date of De	ath Day	Year	3. Time o	f Death
ı,	Physici /Medio		James Peter Hask	ins				February	,	2008	8:00	a_M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of De			County of Deat	h	
			1523 Lady Anne Co			Jarrett				На	rford	
ш	Funeral		Social Security Number     6. Security Number	ex 7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Mi		th y, Year)	9. Birtl	nplace (State ountry)	or For <b>e</b> ign
	Director		021-28-0563 X Usual Residence of Decedent	71	115.			May 12,	193	7 Mas	S	
	land ow		10a. State 10b. County	100	. City, Town or Lo	cation					10d. Inside C	ity Limits
	Mary -feh	to	MD Harford		Jarrettsv	71110					1 ☐ Yes	2. No
	r 28e	Director	10e. Street and Number		allects	10f. Zip Code			10g. Citiz	zen of What Co	untry?	
	3a o		1502 v - 1 - 2 0			27.004			TT	L - 3 OL -		
	deati	Funeral	1523 Lady Anne C	12. Was Decedent Ever Armed Forces?		Was Decedent of F	lispanic Origin?	(Specify Yes or No		ted Sta 14. Race - Ame	rican Indian,	
ဖွ	after or tte	F	1 ☐ Never Married 2 ☐ Married	4	055_	f Yes, specify Cubi		erto Hican, etc.)		Black, White	e, etc.	
8	ours iret'.	d by	3 Widowed 4 Divorced		975	1□Yes 2□No X	Specify:			Specify: Wr	nite	
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or itema 23a or 28e-f ehow he dical Exeminer must be notified at	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occup	during most of w	orkin <b>g</b>	16b. Kir	nd of Business/l	ndustry	
12	within ne.	E I	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	d)		_		- 1	-
	Hygie ther nt, II		17. Father's Name (First, Middle, Last)	2.	insti	cuctor	19 Mother's N	ame (First, Middle,		ineerir	ng Scho	ЮТ
an	d be intral	Be	James Sydney Has	king				ouise Swe				
Maryland	shoul mark matt	ပ္	19a. Informant's Name/Relationship (7		19b Mailir	nn Address /Street		Rural Route Numbe			in Code)	
Š	ulth ar 27 to r trau		Yvonne Haskins - w	ri fo				t, Jarret				
ē,	s 1 a		20a. Method of Disposition		b. Place of Dispo			Date		cation - City or		
Ë	Page ent o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	.1				/00/2000	Hame	- bood -	MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or itema 23a or 28e-f show any Injury or other traumatic event, the Medical Examiner must be notified at ones.		21. Signature of Funeral Service Licen			Cremation . Name and Addre	ss of Facility	/09/2008 E.G. Kuı				Home
m	Depa Impo any la		M. Gladden K	urtz III pe	er dvr <sub>Ja</sub>	arrettsvi	lle MD	D.O. Kai	. 02 0	. DOIL I	ancrar	Home
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the cone cause on each line.	death. Do not ent	er the mode of dyir	ng, such as cardi	ac or respiratory a	rrest,		Approxima Interval Ber	te tween
	Physician		Immediate Cause (Final disease or condition		Dada Da						Onset and	
	/Medical		resulting in death)	Due to (or as a con	Body Der sequence of):	nentla						
Н	Examiner		Sequentially list conditions,	b								
	g ts	lner	cause. Enter Underlying	Due to (or as a con	requence of):					-		
	and I-tran	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a con	seguence of):							
8760,	cate be executed physicien and the burial-transit	calE		240 10 (0. 40 4 00)	334331133 317.							
587		edlc		d								
×	nding use a	Ž.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre	egnancy				2	3d. Date of deli	verv	
.O. Box	death d for	Cla	in the past 12 months?	1□Live birth 2□f 4□Pregnant at time		Ectopic pregnancy Other (specify)	<u>′</u>			Month		Year
0	t the by the ache	Physician/M	9 Unknown	9□ Unknown								
o. võ	The law requires that the death certifi te has been signed by the attending page 2 should be detached for use as	by P	Part II. Other significant conditions co	ontributing to death but not	resulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	obacco us	se contribute to	the cause of	death?
Division of Vital Records,	w require been sign	ed						101	res 20	No 3□Pro	obably 4 🗍	Unknown
၁၁	law re las be	Completed						24a. Was		24b. Were au	topsy findings	available
œ —	The ate h	EOC						autop perfo 1 ☐ Yes	rmed? 2√□ No	death?	No No	ause of
ita	Physicien: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?				26. Place of D	eath (Check only o	-		-AX	
5	Physi this o al dire	ို	1 ☐ Yes 2 ☐ No		2 ER/Outpatien	t 3□ DOA Oth	er: 4 🗆 Nursing	Home & Resid	dence 6	□Other (Spec	afy)	
Z Z	tending Physicien: The leath.  tor: After this certificate he the funeral director, page	ë.	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	Wor		28d. Describe I	now injury	occurred		
Sic	Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	00 51 (1-)			Yes 2 □No	10011	-		10	
<u>&gt;</u>		Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	ecify)	eet, factory, office		28f. Location (5 City or Tov		Number of Hu	rai Houte Nurr	nber,
	Hospital		29a. Certifier 1 Certifying Phy	ysician: To the best of my	knowledge death	occurred at the tir	ne date and place	ce and due to the	rauso(s)	and manner as	stated	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Examone)	iner: On the basis of exame and manner stated.	nination and/or inv	estigation, in my o	pinion, death occ	curred at the time,	date and	place, and due	to the cause(s	5)
	To the To the Complet	ž	29b. Signature and title of certifier	/		29c. Licens	e number		29d, Date	signed (Month	, Day, Year)	
			Clart	L. M	₹)	D523	313		MAR	c4 6,	2008	•
			30. Name and address of person who o	ompleted cause of death (	(Item 23a) (Type,		,			· · · · · · · · ·		
			Charles Locke, MD,	2360 W. Jor	ppa Road	Luthers	ville, M	D				
	Sta: Registra	_	31. Date filed (Month, Day, Yéar) MAR 1 3 20	32. egistrar's S	ignature	retes						
1			MILLIO TO CO	A STATE OF THE STA	Ja Jay	-						

Frank Rodney Jones
08-01473
Please

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **UNK UNK** Certificate of Death 1- For State Reg. No Registrar 2. Date of Death Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day February 20, 2008 0825 hrs Frank Rodney Jones Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Davidsonville 294 Brick Church Road If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Months Days Hours Director 1969 9Mary yland 26 217-86-9394 1 X M 2 F 38 Yrs Sept Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 1 XYes 2 No Annapolis t. Pages 1 and 2 should be filed within 72 hours after death with the Maryland trans of Health and Mental Hygiene.
Trans: If item 27 is marked other than "natural", or items 23a or 28a-f show yor other transus to be notified at once, Maryland Anne Arundel Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number USA 21403 1416 Tyler Avenue 14 Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 2 X No Yes Black Specify: Yes 2 X No specify. Divorced If Yes, Give Year þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Gutter Covers Baltimore, MD 21215-0036 Gutter Tech 12th 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Linda Marie Ewell Frank Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Abingdon Μđ Linda Marie Jones (Mother 202 Ferring Ct 20c. Location - City or Town, State 20b Place of Disposition (Name of cemetery, 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 2-27-08 Annapolis, Md. Memorial Gardens 4 Donation 5 Other Specify: 2 Margar & Constant Folity Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 Tarry 3, Reose no 483 OZI West St. Affiliapolis, Ind.
23a. Part I. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Beese MOOY83 Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. Death (Medica) a. Multiple Gunshot Wounds Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED attending physician are use as the burial -Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year Dav 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown the 2 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? The law certificate has ✓ Yes 2 1 🗸 2 No 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical Be examiner? Other; Nursing Home 5 Residence 6 Other; Scene Hospital: DOA Inpatient 2 ER/Outpatient 3 1 V Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 27. Manner of Death Subject shot Certification: UNKNOWN Yes 2 V No Natura Pending in by the Feb 20, 2008 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) 294 Brick Church Road, Davidsonville, MD Suicide determined (Specify) Woods 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner, stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number February 21, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Chief Medical Examiner David Fowler M.D. egistrar's Signature State 2008 Registra

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7.35 AM Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Basswood Anne Annel /thrapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1√2 M 2□ F 219-30-3774 74 Director May 28 1933 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene.

Important: if them 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Director Annapolis 1 □XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 Basswood Rd. 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 😾 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Aggregate Elementary/Secondary (0-12) College (1-4or 5+) 6th 0 Mixer Driver Industries 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Isaac Johns Sr Ruth Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20705 Cheryl R. Beans(Daughter) 11308 Narrow Trail Terrace Beltsville, Md. 20b Pack Popportion (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Gardens 2-25-08 4 ☐Donation 5 ☐ Other (Specify) Davidsonville, Md. Manuame Rockes of Sacilisons Mortuary, P.A. 21. Signature of Funeral Service Licenses Jarry H, Keese MOO483 821 West St. Annapolis, Md. 21401 Part1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Doath Immediate Cause (Final disease or condition resulting in death) Physician month /Medical Due to (or as a consequence ): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ettending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has tirector, page 2 s autopsy performed? Yes 22 No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ector: / by the f 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled Lacertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 

| Description of the Dasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3008 30. Name and address of person/who completed cause of death (Item 23a) (Type, Print) Bestgate Rd Sute 300 Anna

State

31. Date filed (Month, Day, Year) FEB 2 7 2008 32. gjistrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** Elizabeth Reddington Jones February 25 2008 10:26p.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5 Middle Street Dorchester Vienna If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year June 2, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Yrs Director 213-14-1348 84 1923 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Dorchester MD Vienna 1 X Yes 2 □ No Funeral Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 5 Middle Street 21869 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 █**X**No þ Specify: white 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) iene. Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John W. Hughes Bessie Hurley ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health at Important: If Item 27 is any injury or other trau P. O. Box 163, Vienna, MD Woodrow Jones husband 21869 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Pauls P.E. Cem. 2/28/08 Vienna, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Parkinson 411 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔼 No Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **∂** 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a, Was an page 2 s autopsy performed? Yes 2 ☑ No 2 No To the Hospital or Attending Physician: ours after death.

eral Director; After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 29a. Certifier 155 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies

Registrar DHMH 17 Rev 1/2001

State

MD

Salesbury

gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8101

560 Riversida

31. Date filed (Month,

D24986

Robert J. Reilly mp

2/26/08

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar			Cer	tificate of		2110 1110	R	leg. No.	2008	082	240
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6	Physici /Medic			Guila Eli:	zabeth	Jones	i			February	26,	2008	4:35 P	М
	Examir	er	4a. Facility Name (If not institution	on, give street and numb	per)		4b. City, Town, o		of Death		_	ounty of Deat	th	
			4930 Solomons Isla		A (1 1-	- 4 1 1 46 4- 1	Huntingtow If Under 1 Year		04 Hro 1	Date of Birth	Calv			
	Funeral		5. Social Security Number	6. Sex 7.	. Age (In yrs. la		Months Days	If Under Hours	Min.	B. Date of Birth (Month, Day	, Year)	Co	hplace (State or untry)	Foreign
-	Director		242-34-4463 Usual Residence of Decedent			93 <sup>Yrs.</sup>				February	7, 191	5 Mary	/land	
	fand ow at		10a. State 10b. Count	ty	10c. City,	Town or Lo	cation						10d. Inside City	y Limits
	Mary -f sh	ţ	MD Calve	rt	Hunti	ingtown							1 □ Yes	2 📉 No
	the 28a	rec	10e. Street and Number				10f. Zip Code			1	10g. Citize	n of What Co	untry?	
	3a ol		4930 Solomons Isla	and Road				20639			USA			
	ms 2	Funeral Director	11. Marital Status	12. Was Deced	ent Ever in U.S	. 13. \	Vas Decedent of H f Yes, specify Cuba		gin? (Spec	ify Yes or No-		Race - Ame		
9	after or Ite	Ē	1 ☐ Never Married 2 ☐ Ma		X No		i Yes, specilly Cuba I□ Yes 2∑INo	sn, mexicar Specify:	і, Риепо н	ican, etc.)		Black, White	e, etc.	
8	72 hours after death with the Maryland 'ratural', or Items 23a or 28a-f show dical Examiner must be notitled at	d by	3 ☑ Widowed 4 ☐ Divorce	Year or Date	es:		TES ZEAINO	Specify.			S	pecify:	Black	
21215-0036	72 h 'natu dical	Completed	15. Decede (Specify only high	ent's Education nest grade completed)	ļ	(Give	lent's Usuai Occup kind of work done	durina mos	t of working	7	16b. Kind	of Business/	Industry	
2	/ithin ne. han '	ם	Elementary/Secondary (0-12)	College (1-4	for 5+)		OO NOT use retired	•			_			
5	led w tygie her t	Ŝ	9 17. Father's Name ( <i>First, Middle</i>	2 ( 001)		Scho	ol Bus Contr		wa Nama	First, Middle.		Public Sc	hools	
and	l be f ntal H ed of	Be						18. Motife	i S Maille (			,		
Ĕ	hould d Me mark matic	မ	Johi 19a. Informant's Name/Relation	n Dennis Gross		10b Mailin	g Address (Street	and Numbe	e or Furni			th Smith	Zin Contol	
Maryland	d 2 s th an 7 Is r traur			, , , , ,									zip Code)	
(a)	1 an Heal em 2		Tauhidah M. Oma 20a. Method of Disposition	r - Niece	20b. Pla	ace of Dispo	N. Harry S. T		Drive, L			tion - City or	Town State	
JOI	ages nt of t: If it		1 ⊠ Burial 2 ☐ Cremation		ate cei	metery, cren	natory or other plac					and only of	Toming Guard	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 5 □ Other ( 21. Signature of Funeral Service		P		UMC Cemete . Name and Addre		3/4/200	08	Huntir	ngtown, 1	MD	
Ba	permi Depa Impo any Ir		) Glades C	n // n /	)		well Funeral H			Dares Rea	och Dd	Dringo Er	oderick MD	20675
	*		23a. Part1. Enter the disease,	or complications that cau	used the death.							1 111100 1 1	Approximate	
2	Physician		shock, or heart failure. List Immediate Cause (Final	st only one cause on eac	ch line.	il	Carabo	074	2 cul	n a	icci,	land	Interval Betw Onset and D	eath
	/Medical		disease or condition resulting in death)	a. Due to (o	r as a conseque		0000						118	
	Examiner			Duc to (or	as a conseque	onge on.								
E	<b>%</b>	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b. Eue to (or	r as a nunsequi	inne off:								
	cuted Id ansit	Examiner	Cause (Disease or injury that initiated events											
ó	e exe an ar irial-ti	Ĕ	resulting in death) Last	Due to (or	r as a conseque	ence of):								
68760,	rificate be executed ng physician and as the burial-transit	Medical		d										
		Med	IF FEMALE:	T										
Вох	ath ce ttendi	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	ome pf pregnan th 2 □ Fetal o		Ectopic pregnancy	/			23	d. Date of del Month		ear
<u>.</u>	the a	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnar 9∐Unknow	nt at time of dea n	ath 5□	Other (specify)					WOTH	Day 11	cai
P.O.	The law requires that the death ce tte has been signed by the attendi vage 2 should be detached for use		Part II. Other significant condit	tions contributing to dea	th but not result	ting in the ur	derlying cause giv	en in Part I		23e. Did to	bacco use	contribute to	the cause of de	eath?
Division or Vital Records,	signe	l by	Cascinon	a ct a	Rate	Bre		on my aren		1 🗆 Y		/	obably 4 □U	
Ö	requipeen	etec	SIP POST	Sided	$\overline{\omega}$	25000	Comy				$\overline{}$			
Be	has has ge 2	Completed	011 000				··· }			24a. Was a autops perfor	sy 🖊	prior to death?	utopsy findings a completion of ca	use of
g	s <b>ician:</b> Th certificate rector, pag		OF Management to madin	-						1□ Yes	2/AN0	1 □ Yes	2 No	
⋚	slcia certi irecto	Be c	25. Was case referred to medic examiner?	Hospital:	nationt OFF	E/Outpation	t 3 DOA Oth	or.		Check only or				
o	ing Phys  After this funeral di	To	27. Manper of Death	28a. Date of	Injury 2	28b. Time of	, OLI DOA	4 🗆 NU	rsing Hom	e 5 Reside		☐Other (Spe	city)	
O	th. th. tarte	tio	1 Natural 5 ☐ Pend 2 ☐ Accident inves	ling (Month, stigation	Day Year)	Injury		ƙ? Yes 2 □	No					
<u> </u>	Attending Physician: r death. ector: After this certifici by the funeral director, I	fica	3 Suicide 6 Could	mined Zoe. Place of			eet, factory, office		28	f. Location (S	treet and i	Number or Ru	ural Route Numb	per,
	s afte	Certification:	4   Hornicide	building	g, etc. ( <i>Specity)</i>					City or Tow	n, State)			
	To the Hospital or Attending Physician: The within 24 burs after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical (	29a. Certifier 1. Certify (Check only one) 1. Medica	ring Physician: To the ball Examiner: On the bas and manne	is of examination	ledge, death on and/or in	occurred at the tile vestigation, in my c	me, date ar opinion, dea	id place, ar	nd due to the o	ause(s) a date and p	nd manner as lace, and due	s stated. e to the cause(s)	
	To the within To the compl	Me	29b. Signature and title of certific		MD		29c. Licens	e number		2	29d. Date	signed (Mont	h, Day, Year)	(/
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	) A		30. Name and address of perso	-		23a) (Type,	Print)	200 /	2 ) [	PRINCE	FR	EDER	ICK	-
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	Sta Registr		31. Date filed (Month, Day, Yea.	(r) 32. Reg	gistrant Signatu		barte							

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

5 DH

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death

February

Month

Day

26,

2008

Montgomery

14. Race - American Indian,

Black, White, etc.

Specify: White

4c. County of Death

U.S.A.

 ${\bf P}^{\,\mathsf{M}}$ 

9:45

Birthplace (State or Foreign Country)

Washington, D.C.

10d. Inside City Limits

Approximate Interval Between Onset and Death

3 weeks

vear

10 years

Year

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

23d. Date of delivery

Month

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 X Yes 2 □ No

28a. Date of Injury (Month, Day Year)

Division or Vital Records, P.O. al or Attending P s after death. il Director: After To the Hospital o within 24 hours aff To the Funeral D

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D33443 February 27, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1201 Seven Locks Road #111 Rockville, Maryland 20854 Alan Pollack, MD

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Registrar

Certification:

Medical

31. Date filed (Month, Day, Year) FEB 2 9 2008

5 Pending investigation

6 ☐ Could not be determined

27. Manner of Death

1 X Natural

3 Suicide

29a. Certifier

2 Accident

4 ☐ Homicide

. Decedent's Name (First, Middle, Last)

Dorothy Auerbach Johnson

4a. Facility Name (If not institution, give street and number)

**Physician** 

/Medical

Examiner

Registrar's Signature

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registræmend 29d per Dr. g877 3/13/08 if icates of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** OS Day Year \WA 02 05:20 A M 2008 /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ADVENTIST ROCKVILLE, HOSPITAL MARYLAND GROVE MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day. | 35 | 0.2 | 0.8 | 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 X M 2 □ F NONE Director MARYLAND Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f shov Examiner must be notified at SILVER SPRING, 1 Yes 2 □ No Director MONTGOMERY 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or: HEWITT 20906 IVENUE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Year or Dates: the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) NFAN INFANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be JENG ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SILVER SPRING, Mb 20906 JENG FATHER UUSMAN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Pages 'Department of H Important: If ite any injury or ot once, CYCLE 03/10/2008 21. Signature of Funeral Service License MEDICAL CENTER DRIVE, ROCKVILLE, MD, SGAH 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final IMMATURITY **Physician** TULMONARY disease or condition resulting in death) /Medical Due to (or as a consequence of): PREMATURE RUTTURE OF MEMBRANES **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed HORIOANIONITIS physician and s the burial-tran Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 4☐Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 **X**No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death?
1 ☐ Yes certificate 2 **X**No 2 **N**0 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 ☐ Pending investigation 1 X Natural 2 ☐ Accident (Month. Day Year) **Injury** 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:

completely filled in by the f 3 Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Committee in the cause of examination and/or investigation in the cause of examination and/or investigation in the cause of examination and or investigation in the cause of examination and or investigation in the cause of examination and or investigation in the cause of examination and or investigation in the cause of examination and or investigation in the cause of examination and or investigation and or invest 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2/8/2008 man, mo D55699 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDICAL CENTER DRIVE, ROCKVILLE, MD 20850 RAM, SGAH, 3. Registrar's Signature

State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Maryland	•	rtment of He tificate of D		Mental Hygier	2000	08245
	Physicia /Medic	an al	1. Decedent's Name (First, Middle, Last)		Je	ENG 4b. City, Town, or I	Leasting of Dooth	02 08	Pay Year Pay 2008	
	Examin Funeral Director		4a. Facility Name (If not institution, give s SHADY GROVE ADVE 5. Social Security Number NONE 6. Sex	NTIST HOSPITAL		0	If Under 24 Hrs. Hours Min.	8. Date of Birth	MONTG	thplace (State or Foreign ountry)  ARYLAND
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department if item 23 a or 28a-f show Important: If item 21 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantrational be rediffied in once.	by Funeral Director	Usuel Residence of Decedent  10a. State 10b. County  MD MONTGO  10e. Street and Number  3354 HEWITT	AVENUE	VER (	SPRING, 101. Zip Code	MARY 20906	LAND 10g.	Citizen of What C	10d. Inside City Limits 1 XYes 2 □ No ountry?
21215-0036	in 72 hours after de "natural", or Items edical Evaminer in	Completed by Fune	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grade)	completed)	6a. Deced	Vas Decedent of His Yes, specify Cuban  Yes 2 No  ent's Usual Occupa  kind of work done of  NOT use retired)	Specify:	16b	14. Race - Am Black, Whi Specify: B	ite, etc.  LACK  Vindustry
Maryland 212	ould be filed withi Mental Hygiene. karked other than katic event, the M	To Be Comp	17. Father's Name (First, Middle, Last)	JENG		INFAN	18. Mother's Nam	ne (First, Middle, Maid	FYE	
ore,	Pages 1 and 2 shument of Health and ant: If item 27 Is m ury or other traum		19a. Informant's Name/Relationship (Ty  OUSMAN JENG  20a. Method of Disposition  1 Burial 2 Cremation 3 Pr  4 Donation 5 Other (Specify)	I/FATHER 20b. Place	354 e of Dispos etery, crem ER I	HEWIT sition (Name of pace) CYCLE	T AVEA	Date 20c	SPRIN Location - City o	6,MD20906
Balt	permit. Page Department Important: If any injury o	4	21. Signature of Funeral Service Licens  23a. Part 1. Enter the disease, or complete	Cations that caused the death. I	50	Name and Address AH, 990 or the mode of dying	1 MED		ER DRIVE	Rockville Approximate Interval Between
1760,	Physician Average Physician Average Physician Average Physician and Physician and Physician Phys	icai Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<i>[</i> ]	ice of): IABL ice of): ION	e PREMA	IMMAT TURE RU	-	NEMBRAN	Onset and Death
.O. Box 68	death certific: e attending pl id for use as t	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 PNo 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3	Ectopic pregnancy			23d. Date of do Month	elivery Day Year
Δ.	The law requires that the te has been signed by th bage 2 should be detache	ted by Pł	Part II. Other significant conditions con MATERNAL CE	•	-		n in Part I.	23e. Did tobace	3.00	to the cause of death?  Probably 4 Unknown
tal Reco		e Completed	25. Was case referred to medical				26 Place of Dea	24a. Was an autopsy performed 1 Yes 2 M	? prior to death?	autopsy findings available completion of cause of
Division of Vital Records,	Jing Phys h. After this funeral di	Certification: To B	examiner?  1	28a. Date of Injury (Month, Day Year) 28	VOutpatien  Bb. Time of Injury	28c. Injury Work M 1 \( \text{Y}	r: 4 🗆 Nursing H	ome 5 Residence 28d. Describe how i	njury occurred t and Number or F	
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one) (Check only one) (Check only one)	building, etc. (Specify) sicien: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death	occurred at the tim	inion, death occu	rred at the time, date	e(s) and manner a	ue to the cause(s)
/	0 ¥ 5 8	Σ	29b. Signature and tipe of certifier	W, 100		D55	699	0.	2/08-8	2008
K	Sta Registi		30. Name and address of person who constitute an	329 Hegistral's Signatur	EDICE	IL CENTE	R DRIVE	ROCKVILL	E, MAR	1LAND 20850

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 27 2008 Kober chruary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Easton 105A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** 1**12** M 2□ F Months Days Hours 7-20-0779 Director Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at 1 ☐ Yes 2 PNo Director Talbot a.ordov Pages 1 and 2 should be filed within 72 hours after death with the I nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-10g. Citizen of What Country? Completed by Funeral ellum, Joh, 12. Was Decedent Ever in U.S.

Armed Forces? Navy
1 Wes 2 | No V
1f Yes, Give 1943 Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Black Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Highway Equipment Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kellum Henru Warwick ပ Mamie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cordova, Maryland
20c. Location - City of Town, State Kellum Road. David 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Important: if it any injury or o once, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify)

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Henry Funeral Home, P. A.

510 Washington St. Cambr

23a. Party Enter the disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, smediate Cause (Fine) Easton, Maryland MD. 21613 Immediate Cause (Final halo Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, that it beating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Due to (or as a consequence of): physician ar Division or Vital Records, P.O. Box 68760. use as t IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Minknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No— 24a. Was an page 2 autopsy performed 2 No 2U No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2240 1 hpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1-Natural Injury 1 □ Yes 2 □ No 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide To the Hospital Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature-end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DeShields Dennis M. 219 S. Washington St. Easton, MD 21601 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? For Stete Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Mark S. Kurtzman February 28 2008 12:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 10708 Hillingdon Road Woodstock Howard 8. Date of Birth (Month, Day, Year Aug 16, 1 If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Months 1X M 2 □ F 57 1950 Director 217 50 9333 Ohio Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28e-f show iral', or itams 23a or 28e-f show Examiner must be notified at 1 Yes 2 No Director MD Woodstock Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10708 Hillingdon Road United States or itams 23s 21163 deeth Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Important: if Item 27 is marked other than "netural; or Itan eny injury or other traumatic event, the Medical Exerci-1 Never Married 2 Marned 1 Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vice President of Operations Potomac Inform. Systems 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donald A. Kurtzman Joan W. Simmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10708 Hillingdon Road Woodstock, MD 21163 Nancy L. Kurtzman/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ardent Crematory Hanover, MD <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 3-3-2008 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee a M01044 llis 4112 Old Columbia Pike Ellicott City, MD\_21043 23a. Part 1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between inset and Death Immediate Cause (Final yea **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence o Examiner Sequentially list conditions, Larry leading cause. Enter Underlying Cause (Disease or injury Examiner Due to or as a consequence of The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) signed by the attending physicien Physician/Medicai as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year ō 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by should be 1 Yes 2 🗆 No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2√√2 No has autopsy performed? page 2 certificate 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ٥ 1 Yes 2 XNo 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident in by the Director: 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours To the Funerel 29a. Certifier 1 🛣 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4113 Feb. 29, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Clement Knight 11065 Little Patuxent Pkwy Columbia, MD 21044 31. Date filed (Month, Day, Year) 32. Restrar's Signature State Registrar 2008

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 29 11:28 a.M **Physician** February Edward Allen Lowe 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Dorchester General Hospital Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 X M 2 □ F Yrs June 15, 1943 Maryland Director 218-40-6235 64 Usual Residence of Decedent 10d. Inside City Limits 10b. Counfy 10c. City, Town or Location 10a. State 28a-f show 1 ☐ Yes 2 No item 27 Is marked other than "natural", or items 23a or 28a-f st other traumatic event, the Medical Examiner must be notified Dorchester Cambridge Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code within 72 hours after death with USA 21613 5046 Aireys Road Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) wire cloth mfg. welder 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilbur Lowe Sr. Alice Robbins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5046 Aireys Road, Cambridge, MD 21613 Wanda Lowe wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of Important: If its
any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/4/08 Cambridge, MD Dorchester Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) Thomas Funeral Home P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death Immediate Cause (Final trolle **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2☐Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably Dunknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ₩No 24a. Was an autopsy performed? has page 2 certificate 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Be 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA 1 Inpatient Medical Certification: To after death. 27. Manner of Death
Natural
Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Registrar

State

29b. Signature and title of ee

31. Date filed (Month)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ENMINE

Year)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 () Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2008 7:05 p March 1, Genevieve Adele Anderson Lane 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Calvert Owings 3651 Chaneyville Road 8. Date of Birth (Month, Day, Year) 1914 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex Social Security Number Days Hours Mary Land 1 □ M 2 👿 F 94 212-48-6600 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 XNo Owings MD Calvert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20736 3651 Chanevville Road 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 □ Never Married 2 □ Married white 1 ☐ Yes 2 ☐ No Specify: Specify: 3 

Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nixdorff Anderson **Elsie** Mav Soper E11sworth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3651 Chaneyville Rd., Owings, MD 20736 Mary Anderson Lane, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Owings, MD Mt. Harmony Cemetery Mar. 6,2008 22. Name and Address of Facility Rausch Funeral Home, P.A. 21 Signature of Funeral Service Licensee 8325 Mt. Harmony Lane, Owings, MD loan Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute 1 Chronic jears Due to (or as a consequence of): Congestive Heart Fallure Chronic Acute, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 | Fetal death 3 Ectopic pregnancy Year 1 Live birth Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bronchiectasis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Vulmorary Diease 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy perform Cerebrovascular 1∐ Yes 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1X Natural

**Physician** /Medical Examiner Examiner sician and burial-transit be executed Division or Vital Records, P.O. Box 68760, Physician/Medical

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at

Director

by Funeral

Completed

Be

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death with the Maryland

filed within 72 hours after

s 1 and 2 should be filed wi if Health and Mental Hygier item 27 is marked other th other traumatic event, the

permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr

Baltimore, Maryland 21215-0036

attending physician for use as the buria To the Hospital or Attending Physician: The law requires that the death certificate ed by the a detached f page 2 s certificate after death.

I Director: After this d in by the funeral di within 24 hours aft To the Funeral Di completely filled in

2

Completed

Be

Medical Certification: To

Cerebrovascular

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

6 Could not be determined

28a. Date of Injury (Month, Day Year)

Sterrer M.D.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

5 ☐ Accident

3□ Suicide 4 ☐ Homicide

> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
>
> [ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

D17245

March 3, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

19 Chesapeake Beach Rd.E., Owings, MD 20736 Gerald P. Sterner, MD

State Registrar 31. Date filed (Month, Day, Year) 32. Registras Signature 3 2008 MAR

#### Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible

			For State Ragistrar	State of Mary	land / Dep		f Health and I		_	008	08250	
									Date of Death     3. Time of Death			
Physici /Medi			1. Decedent's Name (First, Middle, Last)  NALLACE D. LECHER TR					Month 02	200	2008	0445AM	
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death						4c. County of Death  WORCESTER			
					SPITAL	BE/		10.5(5)				
	Funeral Director		5. Social Security Number 6. Sex 169-24-1662  Usual Residence of Decedent		77 Yrs. last birthday)	Months Da		8. Date of Bir (Month, Da 3-2-1	930	9. Birthp Cour PENNS	lace (State or Foreign try) YLVANIA	
201	death with the Maryland me 23a or 28a-f ehow frrust be notified at	Funeral Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside							0d. Inside City Limits 1 ☐ Yes 2 ☑ No		
248年8			10e. Street and Number 30872 LONG LEAF ROAD			10f. Zip Code 19939			10g. Citizen o	-		
40	me 2	nera		2. Was Decedent Ever	r in U.S. 13.	Was Decedent	of Hispanic Origin? (S	pecify Yes or No	)- 14. R	ace - Americ		
036	within 72 hours after ene." then "natural", or Ite he Medical Exemine	Ď	Armed Forces?  1 ☐ Never Married 2 ☑ Married   1 ☐ Yes 2 ☑ No   1 ☐ Yes 2 ☑ No   1 ☐ Yes 6 ive   Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☑ No Specify:			Black, White, etc.  Specify: WHITE			
DOD 215-00	hin 72 ho e. en "natur Medical	Completed	(Specify only highest grade completed) (Giv			edent's Usual Occupation re kind of work done during most of working DO NOT use retired)			16b. Kind of Business/Industry			
21	filed wit Hygiene ther the	Com		College (1-4or 5+)		PHYSICI	AN		HEA	LTHCA	RE	
/レレユ DOD - Maryland 21215-0036		To Be	17. Father's Name (First, Middle, Last)  WALLACE O. LECHER, SR.  18. Mother's Name (First, A MAY BI									
			19a. Informant's Name/Relationship (Type, Print)  ANNETTE G. MAHER-LECHER/SPOUSE  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  30872 LONG LEAF RD., DAGSBORO, DE 19939									
₹ -24- Baltimore,	Peges 1 and ent of Healt nt: If Item 2 ry or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Gremation 3 ☐ Re 4 ☐ Donation 5 ☑ Other (Specify)		cemetery, cre CALVARY	matory or other	place)	Date -2008	20c. Location		own, State YLVANIA	
$\sim$	permit. Peges Department of temportant: If Ite eny Injury or of		21 Signature of Funeral Services, LTD.  WEST AVE., OCEAN VIEW, DE 19970									
10		il Examiner	23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between									
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								7 angs	
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687	e X e	dical	d.						<u> </u>		WW W. V - 1	
Lecher JR Records, P.O. Box (	_ On 63	Completed by Physician/Med	1 I we high 2 Estad death 3 Estadio programmy						Date of delive Month	ery Day Year		
echer		d by Ph							Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Munknown			
Cor	w requir	olete							24a. Was an 24b. Were autopsy findings available			
								perfo	autopsy performed? performed? death?  1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No			
<b>€</b>		o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 X Inpatient	26. Place of Death (Check only one)  Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify)							
$ \mathcal{A}  \mathcal{AL} $ ivision of Vital	ding Phys h. After this funeral di	Medical Certification; To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury 28b. Time of Injury Injury		of 28c.	28c. Injury at Work?		28d. Describe how injury occurred			
/A Division	Hospitel of Puners of Funeral Distriction in the principal in the principa		2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
5			29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								tated. o the cause(s)	
	within 2 To the comple	Me	29b. Signature and title of earlifier							9d. Date signed (Month, Day, Year)		
			CM PCAT			D	D0050826 Drive Belin MD			2/29/08		
.5	DIIA		30. Name and address of person who con	npleted cause of death	(Item 23a) (Type,	Print)	Le.1: -	047	7.18	11		
0	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	JANA	- DYYN	IVID	210	′ /		
	Registr	ar	MAR 3 20	UO REPAR	o St. fr	The state of						

The law requires that the death certificate be executed P.O. Box 68760, physician s the burial signed by the a Division or Vital Records, certificate has b irector, page 2 sl Hospital or Attending Physician: this neral Director: , filled in by the f within 24 hours at To the Funeral Completely filled

Show

and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier

(Check only one)

1 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 12-CZ MD 29c. License number D18019 29d. Date signed (Month, Day, Year) MARCH 11, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 340 MILL ST DATTHMO

MAGERSTOWN MO

State Registrar

Medical

31. Date filed (Month, Day,





DR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Day Februa Mabel Marie Long 26 2008 /Medical 4a. Facility Name (If not institution, give street and numb 4c. County of Death Examiner SALISBUL IONAL ediase Woom 100 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 2/28/1928 Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1□ M 2**X**F Maryland 220-26-2789 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 USA 3231 Slim Chance Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry v. 27 is marked other than "traumatic even" Elementary/Secondary (0-12) College (1-4or 5+) domestic 11 homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eva Mae Dryden William Bromley ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10932 St. Martins Rd., Berlin, MD 21811 Lois Ann Hayman/daughter permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. once, 20b. Place of Disposition (Name of cemetery, crematory or other place Springhill Memory Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/1/08 Hebron, MD 21. Signature of Funeral Service Litensee 22. Name and Address of Facility Holloway Funeral Home Professional Association BUK CFTP 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Ivac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending ph I for use as t IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown şignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1☐ Yes 2☐No 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 2 No Ulcer 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: 1 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 24 hours after death. ■ Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2

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State Registrar 31. Date filed (Month, Day, Year) FEB 2 8 2008

32 Registrar's Signature

d address of person who completed cause of death (Item 23a) (Type, Print)

1.0. 100 E. CAKKIN ST. SAUSBURY MB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend line 29d per phy State of Maryland / Department of Health and Mental Hygiene aaco hlth dept 03/03/08 dlw Reg. No. 20 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 20 2008 **Physician** Florence V. Murray 0149 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 8. Date of Birth (Month, Day, Aug 12 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral <sup>Year)</sup> 1927 Months 1 □ M 2√2 F Days Hours Maryland 212-26-8907 80 Yrs Director Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Howard Director Columbia 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10327 Twin River Rd. 21044 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2√∑ No Specify: ģ Specify: Black 3 ➡Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) United States College (1-4or 5+) Elementary/Secondary (0-12) 6th Chef Supervisor Naval Academy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dennis Harold Lerow Stansbury ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Vernon(Daughter) 10327 Twin River Rd. Columbia, Md. 21044 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 11万 Burial 2 □ Cremation 3 □ Removal from State Broadneck UMC 2-28-08 Annapolis, Md. 4 Donation 5 ☐ Other (Specify) Manuame Reseases of cisons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West ST. Annapolis, Md. 21401 MOO483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician cartions chemic 6 N disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the atten detached for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknowr 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: Certification: To 1 ☐ Yes 2 No 1 patient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day Year) Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral L Hospital \*\*Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2. To the I 29c. License number 29d. Date signed (Month, Day February 20 29b. Signature and title of pertifier 2008 1) 33936

Registrar

>0 C

2008

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 21081S. Darato

Wrive Chesky Mid 2/6/9

31. Date filed (Month, Day, Year FEB 2

trar's Signature Eleve.

			1 - For State Registrar		Ce	rtificate of	Death	ornar ry	Reg. No. 1008	08254
17	Physician		1. Decedent's Name (First, Middle, La	ist)				2. Date of De Month	ath Day Year	3. Time of Death
- K	Physici /Medio		Frederika	Elizabe	th Me	eerman		Februa	ary 25 2008	9:20 P™
	Examin		4a. Facility Name (If not institution, give				r Location of Death		4c. County of Deal	
	24		Calvert Memoria				Frederic		Calver	
Ü	Funeral Director		213-40-7493	ו אות אים אותו	e (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Nov • 2		thplace (State or Foreign ountry) Netherlands
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Maryla I-f sho fied at	tor	MD Calve	rt	Dunkir	k				1 ☐ Yes 2 🛣 No
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	th wit 23a o		2050 North Plan	tation Dri	ve	207	'54		United Sta	ates
215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hyglene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 📆 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces?  1 Yes 2 If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	lispanic Origin? (Spe an, Mexican, Puerto Specity:	ecify Yes or No Rican, etc.)	14. Race - Ame Black, Whit Specify:	
Š	2 hou	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	oation		16b. Kind of Business	/Industry
215	hin 7 e. an "n Medi	Completed	(Specify only highest gr	College_(1-4or 5	i+)		during most of worki d)	ng		
21	filed within Hygiene. Ither than "	Š		1	Но	memaker			Own Home	e 
nd	be file	Be (	17. Father's Name (First, Middle, Las.					·	, Maiden Surname)	
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Maryland	and 2 should be fi salth and Mental H n 27 is marked otl er traumatic ever		19a. Informant's Name/Relationship			-			per, City or Town, State, .	Zip Code) 20754
	1 and 2 Health em 27 i		Christiaan Meer	man, spous	20b. Place of Disp	osition (Name of	; [	Date Date	unkirk, MD  20c. Location - City or	
Baltimore,	Pages nent of h		1 👿 Burial 2 □ Cremation 3 [		cemetery, cre	ematory or other pla	ce)		•	
語	수타라		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice						Clinton, I uneral Home	
Ba	Depail Impol any Ir		Grand of Arterial Service Clock	1/2					ne, Owings,	•
	1,775		23a. Part1. Enter the disease, Con	nplications that caused	the death. Do not er					Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each II	ne. Le /		(	1.	. 0	Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as	a consequence of):	010119	19 50	gravo	me	
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
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Ö,	e exe ian al urial-t		resulting in death) Last	Due to (or as	a consequence of):					
68760,	rtificate be executed ng physician and as the burial-transit	Medical		_d						
			IF FEMALE:							all case
P.O. Box	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 27 No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal death 3	□Ectopic pregnand □ Other (specify) _	у		23d. Date of de Month	livery Day Year
	res that signed b		Part II. Other significant conditions				ven in Part I.	23e. Did	tobacco use contribute t	o the cause of death?
Ď	w require been sig should b	edb	End Stac	e 14 no	1 0,5	ease		1 🗆	Yes 2500 3□P	robably 4 Dunknown
Vital Records,	aw re	Completed by	Type:	I Dial	seks Me	ellitus		24a. Was		utopsy findings available completion of cause of
æ	The lay	E	. 3						ormed? death?	•
ita	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Deat			
or V	hysic nis ce I direc	To	1 Yes 2 No	Hospital: 1 Inpatio	ent 2 ER/Outpatie	ent 3□ DOA Oti	her: 4 Nursing Ho	me 5 Res	idence 6 □Other (Spe	ecify)
n 0	ding Ph J. After th funeral		27. Manner of Death  1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time ny Year) Injury	Wo	rk?	28d. Describe	how injury occurred	
sio	tendi eath. or: A	cati	2 Accident investigation 3 Suicide 6 Could not i	00			]Yes 2□No			
Division	l or Attending Physician: after death. Director: After this certifica I in by the funeral director, p	Certification:	4 Homicide determined	28e. Place of III	ury - At home, farm, s tc. <i>(Specify)</i>	treet, factory, office		28f. Location ( City or To	(Street and Number or F own, State)	lural Houte Number,
	pital		29a. Certifier Certifying P	hveiclen: To the heet	of my knowledge, des	th occurred at the t	ime date and place	and due to the	e cause(s) and manner a	us stated
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Exa	miner: On the basis of	of examination and/or i	nvestigation, in my	opinion, death occur	red at the time	e, date and place, and du	ie to the cause(s)
	o the	Me	29b. Signature and title of certifier	1		29c. Licen	se number		29d. Date signed (Mon	th, Day, Year)
	- > = O		) / h	11			033123	,	2.26-	08
			30. Name and address of person who	completed cause of o	leath (Item 23a) (Type		/ /		0 20	
de	w 5		Jonathan Lowent				, Suite 31	.O, Pri:	nce Frederi	ck, MD 206
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	rans Signature	-4			-	
	Regist	ar	FEB 7	2 9 2008	Malery S.	doct.	ø.			

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 3:35 AM Samuel M. Mills 2008 February /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9288 Hickory Mill Road Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplece (State or Foreign Country) 8. Dale of Birth (Month, Day, Year) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 113€M 2□ F 94 27, 1913 Director 221-03-2370 Delaware Usuel Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral', or iteme 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 22000 Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number ۵ 9288 Hickory Mill Road 21801 U.S.A. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or tien any injury or other traumatic event, the Michigal Exartinal. once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Chemist Chemical Manuf. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George S. Mills Lulu M. Bailey ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Daughter) 8219 Reservoir Rd. 20759 Michael Ann Norwood Fulton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Crematory of Delmarva 02-29-2008 Delmar, Delaware ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Short Funeral Home 13 E. Grove Street 21. Signature of Funeral Service Licensee - Crow eld Delmar, DE 19940 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or need the failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** TITEROY ERATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dec 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown signed by d 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 ☑Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page this certificate 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to-medical 26. Place of Death | Check only one) Be examiner? Hospital: 1 | Inpatient 4 Nursing Home 5 Residence 6 Dother (Specify) 1551576 Other: 2 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA ö After th funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide fo the within 24 hours the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Umf 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN SHIRE YK, SACISBUKY MD 6/4 32. A gistrar's Signature State FEB 2 8 2008 Registrar

08-01723
Corey Moore
Dhyni

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar 2. Date of Death Time of Death hysician/ 1. Decedent's Name (First, Middle,Last) Month Day February 29, 2008 1415 hrs Medical Examiner Corey L. Moore 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Fort Washington 7715 Webster Lane If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) **Funeral** Foreian Davs Months Hours Director 4 Country ississippi 1 X M 34 2 F 428-27-6177 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location s 23a or 28a-f show e notified at once. 1 X Yes 2 No Clarksdale Mississippi Coahoma hours after death with the Maryland rector 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 312 Elm Avenue . A Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 1 Yes Specify:Black 3 Widowed Yes 2 X No specify: "natural", þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene. If item 27 is marked other than her traumatic event, the Medical Education-Universitk Student 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Naomi Moore Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Naomi Martin Andrews Clarksdale, Mississippi 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Itimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Lyon,Mississippi tant: 3-8-08 McLaurin Garden Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Marzullo Funeral Chapel, P. nechack Road, Baltimore, Maryland2121 Harford 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Diabetic Ketoacidosis Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner couse. Enter University of Couse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical physician the burial -UNPENDED X AMENDED 23a, 27 per ME g877 3/17/08 amh Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown the 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 햣 1 Yes 2 No 3 Probably 4 V Unknown Completed Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? page ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Be Other 4 examiner? Hospital: 1 Innatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene this 1 🗸 Yes No Division of 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death 1 X Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

egistrar's Signatu 31. Date filed (Month, Day, Year)

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

March 1, 2008

30. Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD.

State of Maryland / Department of Health and Mental Hygiene For State State Registrar amend 26 per MD g877 amh 3/19/108 Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death Time of Death <sup>Day</sup> 23, 2008 **Physician** DONALD RALPH MOSER JANUARY 17:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner WMHS - MEMORIAL CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Aug. 18, 1935 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1**X** M 2 □ F 72 233-50-9658 Director Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No WV Director Paw Paw Morgan 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 207 Winchester Street 25434 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 **X**Yes 2 □ No If Yes, Give Year or Dates: **1958–64** 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify Specify: White 3 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Storekeeper Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ralph Moser Myrl Powers ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) P. O. Box 243 Paw Paw, WV Geraldine Moser/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State Camp Hill Cemetery 1/26/2008 Paw Paw, WV 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Kimble Funeral Home 188 Mosser Avenue, Paw Paw, WV mell Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 10 YEARS CHRONIC OBSTRUCTIVE PULMONARY DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a surreague rea of) Examiner certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical the as IF FEMALE: ise s 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. 2 HYPERTENSION, PROSTATIC CARCINOMA 3 Probably 4 □Unknown 1 Yes 2 No cate has been signal page 2 should be Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 📉 No 3**X**) DOA ၉ 2 ER/Outpatient ce 6 □Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. lospital or Attend hours after death. uneral Director; 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 17 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. To the I within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D47699 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KINSEY, RONALD C., M.D., 600 MEMORIAL AVENUE, EMERGENCY DEPT, CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 13 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 21 2008 FEBRUARY CLEMENT L. NEDD 8:10 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, SEPT 8) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1947 WEST INDIES 1 ★ M 2 □ F 093-46-3726 60 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1√Yes 2 No PRINCE GEORGE'S BRANDYWINE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13412 YELLOW POPLAR LAND 20613 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married BLACK 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRANSPORTATION PLANNER GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) THOMAS A. NEDD ELTINA BERNARD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13412 YELLOW POLARD LANE BRANDYWINE, MARYLAND 20613 ANNE L. NEDD/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) GASKINS FAMILY PLOT: 3/4/2008 VANCEBORO, NORTH CAROLINA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) He notice ence halo sty due to advand lim Cintal 41Kms Hat hemm mega Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of). Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ▶ Yes 2 □ No 24a. Was an autopsv performed' 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

**Funeral Director** 

Completed by

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar more.

Examine burial-tran the attending properties for use as been signed by the should be detached 3 page 2 s director. Be funeral After

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician/Medical Completed after death filled in by the

Medical Certification: To

To the Hospital or Attending Physician; within 24 hours a To the Funeral I completely

State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

M.D.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

🗡 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2.26.08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

980, Georgia A 31. Date filed (Month Day, Year) it 3-51 ROINTAN FARAH FAR MO

3 ☐ Suicide

29a. Certifier

4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08259 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 23, 2008 7:05 P. M Carol Marie 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's St. Mary's Nursing Center Leonardtown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 ☐ M 2 ☐ XF 79 South Dakota 23,1929 503-26-9724 Jan. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 No 2 No Maryland St. Mary's Leonardtown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21585 Peabody Street 20650 Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 18b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary U.S. Government 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Rose Sauer Charles Oleson 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) 2967 South Columbus Street Apt. A2 19a. Informant's Name/Relationship (Type, Print) Arlington, VA 22206

20b. Place of Disposition (Name of cemetery, crematory or other place).

Geo. Wash. University Kathleen Noel/Daughter Date 20c. Location - City or Town, State 20a. Method of Disposition February23 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 1 4 Donation 5 ☐ Other (Specify) 2008 Medical Center 22. Name and Address of Facility Columbia Mortuary Services, P.A. 21 Signature of Funeral Service Licensee

**Physician** /Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Madical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene important; if Item 27 is marked other than "natural", or Items 23a any jinjury or other treumatic event, the Medical Examinar measure once.

Baltimore, Maryland 21215-0036

Funeral Direct

Completed by

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with the Maryland

Examine the attending physician and by Physician/Medical detached page 2 To the Funeral Director: All To the Funeral Director: All to the funeral Director:

Division of Vital Records, P.O. Box 68760

1 Dute Sent	9013 Annapolis Road, Lanham,	MD 20706
23a. Part1. Enter the disease, or complications that caused the deat Do n shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such a cardiac or respiratory arrest,	Interval Between
Immediate Cause (Final disease or condition	Coronery Event	Onset and Segith
resulting in death)  a.  Due t' (or as a consequence of	on): 1 4 1	7,772.55
Sequentially list conditions, b. Corona	my Holdry () & -	ysan
rany, leading to immediate cause. Enter Underlying	the o with	i la i
Cause (Disease or injury that initiated events c.	yea Hurrosclaros	a year
resulting in death) Last Due to (or as a consequence of	<b>*</b>	1
d	$\mathcal{J}$	<u> </u>
IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	Month Day Year
1 ☐ Yes 2- No 9 ☐ Unknown 9 ☐ Unknown	o do o do o do o do o do o do o do o d	
Part II. Dther significant conditions contributing to death but not resulting in	the underlying cause given in Part I. 23e. Did tobac	co use contribute to the cause of death?
	1 ☐ Yes	2 ■ No 3 □ Probably 4 □Unknown
Hypartantion ) S/Allrob	24a. Was an	24b. Were autopsy findings available prior to completion of cause of
i Descration	autopsy performed	death?
25. Was case referred to medical	26. Place of Death (Check only one)	
examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Out	tpatient 3 DOA Other: 4 Nursing Home 5 Residence	e 6 Other (Specify)
(Month Clay Vocal) Is	Time of 28c. Injury at 28d. Describe how highly Work?	
2 Accident investigation	M 1 ☐ Yes 2 ☐ No	
3 Suicide 6 Could not be determined 28e. Place of Injury : At home, Iai building, etc. (Specify)	rm, street, lactory, office 28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
29a. Certifier 1 Certifying Physicien: To the best of my knowledge	, death occurred at the time, date and place, and due to the caus	e(s) and manner as stated.
(Check only one)  2 Medical Examiner: On the basis of examination and and manner stated.	d/or investigation, in my opinion, death occurred at the time, date	and place, and due to the cause(s)
29b. Signature and title of certifier	29c. License number 29d.	Date signed (Month, Day, Year)
formal sarvos A	06417	2-24-08
30. Name and address of person who completed cause of death (Item 23a) (	21303 1000001	
James P. Jarbroe, M.D.	Leonardtown, MD 20650	

State Registrar

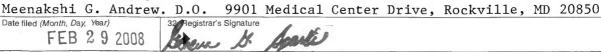
31. Date liled (Moi

Registrar

31. Date filed (Month, Day, Year) FEB 2 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certific



29c. License number

D66189

29d. Date signed (Month. Dav. Year)

2/21/2008

	1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of F rtificate of			giene () () Reg. No.	8 08261
4.00	1. Decedent's Name (First, Middle	•				2. Date of Dea	ath Day -	3. Time of Death
Physician /Medical	Anna	E	Powell			Mar 5,		2:31pm <sup>™</sup>
Examiner	4a. Facility Name (If not institution, Devlin Manor No.			Cumber			4c. County o Allega	ny
Funeral Director	220-30-7996		(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin Month 20,	<sup>v.</sup> 1910	9. Birthplace (State or Foreigr
	Usual Residence of Decedent  10a. State 10b. County  MD Alleg	any	10c. City, Town or Lo	berland				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
olographs autilised	10e. Street and Number 10 N. Liberty St			10f. Zip Code	21502		10g. Citizen of W	
Surdicerrous by Funera	11. Marital Status  1 □ Never Married 2 □ Marri  3 ★ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces?		Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.)	Black	- American Indian, , White, etc. white
t, the Medical Extendion Completed by	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education grade completed)  College (1-4or 5-	(Give	DO NOT use retire	during most of work	king	16b. Kind of Bus	
event, the	12' 17. Father's Name (First, Middle, I William Elkins		Dietar	y Dept.	18. Mother's Nam	ne (First, Middle, Barnhart	Maiden Sumame Elkins Zo	l Hospital ollner
traumatic To	19a. Informant's Name/Relationsh Kenneth Reiber		19b. Mail 1000	ng Address (Street VanBuren	and Number or Ru Ave.	ral Route Numb Cuml	er, City or Town, S Derland	State, Zip Code) MD 21502
Important: if item 27 is marked other then naturel, or items 23s or 25e-1 show eny injury or other traumatic event, the Medical Extratuer rount to incitied at once.  To Be Completed by Funeral Director	20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (Sp.		20b. Place of Disp cemetery, cre Sunset Mei	osition (Name of matory or other pla norial Park	(CO)	Date 3/10/2008		city or Town, State
eny injury	21. Signature > Frineral Service	11 11 11 -	2		ili funeral H ginia Avenu		rland MD 3	21502
	23a. Part1 Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lin	the death. Do not en					Approximate Interval Between Onset and Death
ician dical niner	disease or condition resulting in death)	Due to (or as a	a consequence of):	cesser K	24			yen
in and rial-transit Examiner	Sequentially list conditions, if any, leading to initial diate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as t	s consequence of):					
nysicia he bur	resulting in death) Last	Due to (or as a	a consequence of):					
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnand □ Other (specify) _	ey .		23d. Date Mor	e of delivery tth Day Year
2 2	Part II. Other significant condition	ns contributing to death be	ut not resulting in the	underlying cause g	ven in Part I.			ibute to the cause of death?  3 Probably 4 Unknown
centificate has been si lirector, page 2 should to Be Completed						24a. Was auto perfo 1 Yes	psy pormed? d	Vere autopsy findings available rior to completion of cause of eath?
ertifica ector, j Be C	25. Was case referred to medical examiner?				26. Place of Dea		and the same of th	
this aid	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendin	28a. Date of Injui (Month, Da)	nt 2 ER/Outpatie ry 28b. Time V Year) Injury	of 28c. Inju	ther: 4 Nursing H		idence 6 Other	
al Director: Altert ed in by the funera Certification:	2 Accident investig 3 Suicide 6 Could a 4 Homicide determ	ot be 200 Place of Inju	ury · At home, farm, s c. (Specify)				(Street and Number wn, State)	er or Rural Route Number,
To the Funeral Director: Atter completely filled in by the funer Medical Certification:	29a. Certifier 12 Certifyin (Check only 2 Medical	g Physician: To the best of Examiner: On the basis of and manner sta	examination and/or i	th occurred at the nvestigation, in my	time, date and place opinion, death occu	i a, and due to the urred at the time	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)
Сощр	29b. Signature and title of certifie	Talle h	W		00 /7:56	5	_	(Month, Day, Year)
	30. Name and address of person		eath (Item 23a) (Type	Print) Huy	L2V21-	e , 170	215	02
State Registrar	31. Date filed (Month, Day, Year)  MAR 1 4 2	72. Registra	ar's Signature	<b>43</b>				
1 17 Rev 1/2001		•	ORIGII					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Maryland /	-	artmen rtificat				-	giene Reg. No.	211	08	081	262
			Decedent's Name (First, Middle, La	ast)							Date of De	eath			3. Time of	Death
-	Physici		Joaquim (	Goncalves	s Palme	eiro					Month oruar	y 24	, 20	Year 008	4:12p	M
1	/Medi Examir		4a. Facility Name (If not institution, gir	ve street and num	ber)		4b. City,	Town, or	Location	of Death			County		h	
1	- Adilli.		17219 King James	Way, #20	03		Gait	hers	burg					Mon	tgomery	7
	Funeral				7. Age (In yrs. last	birthday)	If Under				ate of Bir	th	$\overline{}$	9. Birtl	nplace (State o	
В	Director		220-60-1737	1□M 2□F	72	Yrs.	Months	Days	Hours	Min. Oct	Month, Da $oldsymbol{1}$	ay, rear) 19	35		untry) rtuqal	
	70		Usual Residence of Decedent						11	\						
	rylan how		10a. State 10b. County		10c. City, To	own or Lo	cation								10d. Inside Ci	
	a-f s	cto	Maryland	Montgon	nery	Roc	kvill	e							1 ☐ Yes	2 X No
	or 28	Director	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of W	Vhat Co	untry?	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	2	420 Park Road				208	377				USA				
	dea	Funeral	11. Marital Status	12. Was Deced	dent Ever in U.S.	13.	Was Deced	dent of H	ispanic Ori	igin? (Specify n, Puerto Rica	Yes or No	)-		e - Ame	rican Indian,	
9	after or its	F	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes	2₹ No		1 ☐ Yes 3				., 0.0.,		Specify:			
8	ours Fral",	d by	% ☑ Widowed 4 ☐ Divorced	Year or Da	tes:	20+3	7		ороспу.			:	эреспу.	. *****	100	
Maryland 21215-0036	72 h natu dical	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	10	6a. Dece (Give	dent's Usua kind of wo	al Occup	ation during mos	st of working		16b. Ki	nd of Bu	siness/	Industry	
2	ithin Pan " Mee	du	Elementary/Secondary (0-12)	College (1-	4or 5+)	`life.	DO NOT us	se retirea	1)							
2	ed w ygier ier th	Ö	8			_Sel	f Emp	loye							velopme	ent
Б	tal H	Be	17. Father's Name (First, Middle, Las	t)					18. Mothe	er's Name (Fir	st, Middle	, Maiden	Surnam	e)		
Va	Ment arkec	ပို	Joao Palmeiro						Jı	ulianna	a Mar	tins	-Gon	ncal	ves	_
a	2 shc and is mi		19a. Informant's Name/Relationship		1		_			er or Rural Ro		-		State, Z	(ip Code	
≥	and salth		Manuel Palmeiro/S	Son	42	20 Pa	rk Ro	ad,	Rock	ville,	MD 2	0850				
Baltimore,	of He of He item		20a. Method of Disposition	7p		e of Dispo	sition (Nar	ne of ther plac	e)	Feb. Date	29,	20c. Lo	cation -	City or	Town, State	
Ĕ	Page nent int: If		3 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	_Hemoval from S ify)	Gate	of H	leaver	Cen	neter			Silv	er S	Spri	ng, Mary	/land
alti	mit. Sorta Porta / Inju		21. Signature of Funeral Service Lice	ensee						Yins Fu						
m	permi Depar Impor any Ir once.		Dalan s	Cal	7										na.MD 2	20001
			23a. Part1. Errer the disease, or con	nplications that ca	used the death.								er s	ppri	Approximat	e
	Die state d		shock, or heart failure. List only Immediate Cause (Final	one cause on ea	ich line.									- 1	Interval Bet Onset and	
	Physician /Medical		disease or condition resulting in death)	a	Ischemic		rt Di	seas	se					-	15 Yea	ars
7	Examiner			Due to (c	or as a consequenc	ce oi):										
		<u></u>	Sequentially list conditions,	b. Due to (c	or as a consequenc	ce of):								-		
B	ted nsit	를	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		, , , , , , , , , , , , , , , , , , , ,	/-										
D	cate be executed oblysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (c	or as a consequent	ce of):										
8760,	be e ician buria			,		,										
87	cate physi	dic		_d												
9 ×	leath certifica attending ph for use as th	Physician/Medical	IF FEMALE:	220 If you outo	ome pf pregnancy											
Вох	death of attended for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bi	rth 2 ☐ Fetal dea	ath 3	Ectopic p		,			1	23d. Dat Moi		-	Year
	the s	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregna 9⊟Unkno	ant at time of death wn	1 51	Other (sp	еспу)								
P.0	w requires that the de been signed by the should be detached	Ph	Part II. Other significant conditions	contributing to do	ath but not reculting	e in the u	ndorlying o	augo give	on in Dart I		230 Did	tobacco i	lee conti	ribute to	the cause of	death?
Š,	res ti	by				g in the u	indenying c	ause givi	en in anti							
orc	sen s	Completed by	_Chronic Kidney [	isease,	Anemia					-	''	165 2	140	_ 2∏ LI	obabiy 4🔽	OTIKTIOWIT
ů,	law as b	be									24a. Was auto		24b. V	Were au	topsy findings	available ause of
<u>m</u>	The ate ha	PO									perfe 1 Yes	ormed? 2 □ No		death? I □ Yes	·	
ij	ian: ertific ctor,	Be (	25. Was case referred to medical examiner?						26. Place	e of Death (Ch	eck only	one)				
7	Physician: this certific al director,	2	1 Yes 2 No	Hospital: 1 ☐ In	ıpatient 2 ☐ ER/	Outpatie	nt 3 DO	A Oth	er: 4□ Nu	ursing Home	5 🗌 Res	idence	6 StOth	er (Spe	cify) Son	¹ s
Division or Vital Records,		اڃا	27. Manner of Death 1  Natural 5  Pending	28a. Date o	f Injury 28i	b. Time o	f 2	8c. Injur Worl	y at k?	28d.	Describe	how injur	y occurr	red	Res:	idence
.0	Attending r death. sctor: After y the fune	atic	2 Accident investigation	n .			М		Yes 2□	No						
<u>Vis</u>	er de	itic	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place	of injury - At home, ig, etc. (Specify)	, farm, sti	eet, factor	, office			Location (			er or Ru	ıral Route Nun	nber,
	s after s all Dir	Certification: To			9, 0.0. (0,)						,	,				
	Hospital 24 hours a Funeral tely filled				best of my knowled											-)
	ne H	edical	one)	and mann	sis of examination er stated.	and/or ir	ivestigation	, in my o	pinion, dea	ath occurred a	it the time	, date and	) place, a	and due	e to the cause(	S)
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier		/		290	. Licens	e number			29d. Dat	le signe	d (Mont	h, Day, Year)	
	7		1//	w	ly					D206	74	Fe	brus	arv	27, 20	38
	1		30. Name and address of person who	completed cause	of death (Item 23)	a) (Type	Print)	-								
			Stephen Hellman,		240 Montr	, , , , .	,	Re	ockvi	lle, MI	208	352				
	Sta	ate	31. Date filed (Month, Day, Year)		egistrar's Signature	1	45									
			FFR 2 9 20	INS   Real	H	1300	2062 8									

DHMH 17 Rev 1/2001

08-01936	
Amy Pevey	

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my Pevey	State 1- For State	of Maryland / D		Health and		Hygiene	20	08 0826
Physician/ ledical Examiner		st)				2. Date of Deat Month March 8, 2	Day Year	3. Time of Death 2002 hrs
	4a. Facility Name (if not institution, given 5630 Bartonsville Road	e street and number)	4	b. City, Town, or L Frederick	ocation of Dea		4c. County of Frederick	
Funeral Director	5. Social Security Number 6. S 217-06-5687 1		yrs. last birthday) 8 Yrs.	If Under 1 Year Months Days	If Under 24H Hours M		,	9. Birthplace (State or Foreign Country) Virginia
Maryland 28a-f show any 1 at once ector		erick 10c.	City, Town or Locati	∘n Frederi	ck			10d. Inside City Limits  1 Yes 2 X No
the Maryland a or 28a-f sh tified at onc Director		e Road		10f. Zip Code 21	704	10	Og. Citizen of Wha United	it Country? States
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	3 Widowed 4 Divorced	1 Yes 2 X If Yes, Give Year or Dates:	No If Ye	S Decedent of Hispes, specify Cuban, Yes 2 X No	Mexican, Puer specify:		14. Race - White, Specify:	White
5-0036 ed within 72 hour lygiene other than "natu b-Medical Exar Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during me	ost of working life. istrativ	DO NOT use re	etired) Stant	Agric	culture
21215-0036 21215-0036 butd be filed within 7 Mental Hygiene. marked other than ic event, the Medica FO BE COMPIE	Charles A. Hai	rfield	19h Mailing		Patty			State Zin Code)
e, MD 21 and 2 should tealth and Me item 27 is ma traumatic ev	Jonathan Pevey	/ Husband	20b. Place of Disposi	ition (Name of cerr		Road, Fre		, State, Zip Code) Maryland 21704 City or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	1 Burial 2 X Cremation 3 4 Donation 5 Other Specify 21. Signature of Funeral Service Logical	<u> </u>	Smithsburg	g Cremato	ory 1	4, 2008		burg, Maryland Funeral Home
Physician	23a. Part I. Enter the disease, or comparities that compared to the compared t	M01	433   10	6 East Chu	rch Stree	et, Frederi	ick, Maryla	and 21701
/Medical xaminer	failure. List only one cause on ending in the limited in the limit	ach line. Mixed Drug  Due to (or as a conseque		e, cocaine)	and alc	ohol intox:	ication ———	Between Onset and Death
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conseque	nce of):					
e executed cian and rial - transit dical Examiner	events resulting in death) Last	Due to (or as a conseque	nce of):					
ox 68760 ath certificate by ttending physi or use as the bu	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	AMENDED 23a, 27  23c. If yes, outcome of 1 Live birth 4 Pregnant at time 9 Unknown	pregnancy 2 Fe	ME g877 3/ tal death 3 [ ther (Specify)	26/08 am		23d. Date of o	delivery Day Year
S, P.O. Bc uires that the de- n signed by the a lid be detached fo	`	contributing to death but	not resulting in the u	nderlying cause g	iven in Part I.	1 Yes	8 2 No 3	oute to the cause of death?  Probably 4  Unknown
of Vital Records, in Physician: The law requires the this certificate has been signeral director, page 2 should be 1: To Be Completed						1 ✔ Yes	osy pr rmed? de	Vere autopsy findings available rior to completion of cause of eath?  Yes 2 No
f Vital Physician: or this certif ral director,	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2 ER/Outpatient		of Death (Checother)		Residence 6	Other: Scene
ion of tending Pheath. or: After the funeral	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigat	28a. Date of Injury (Month, Day, Year) found 3/8/08	28b. Time of li	_ 1 7	y at Work? es 2 X No	28d. Describe	how injury occurre	id
Division o To the Hospital or Attending within 24 hours after death To the Funeral Director: Aft completely filled in by the fune ledical Certification:	3 Suicide 6 X Could not determine	be 28e. Place of Injury	- At home, farm, stree Scene		uilding, etc.	28f. Location (	Street and Numbe State 5630 Bau	r or Rural Route Number, City rtonsville Road
To the Hos within 24 h To the Fun completely	(Check only one) 1 Certifying Physic one) 2 Medical Examine	ian: To the best of my kno r:On the basis of examina and manner stated.					and place, and du	ue to the cause(s)
Σ	Talini	101	1	29c. License O.C.N			29d. Date signe March 9, 20	ed (Month, Day, Year)
		stant Medical Exam	iner 111 Pen	n Street, Balti	more, MD 2	21201		
State Registrar		32. Pigistrar's S	ignature	W.				
DHMH 17 Rev 1/2001 OCME 2006	***************************************		ORIGINA	L			OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 5:30 a Carolyn Fay Rabunsky February 28, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care-Wheaton Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 TF Director 229-30-9173 79 31, 1928 Virginia Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show ust be notified at 1 ☐ Yes 2 ☐ No Director Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ural", or items 23a 10708 Huntley Avenue 20902 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White þ 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Medical 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If Item 27 Is marked other than ' ury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Teacher \$econdary School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John N. Caricofe Lillian Rhodes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin Rabunsky/Husband 10708 Huntley Avenue, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or conce. 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb. 29, Metropolitan Crematory 2008 Alexandria, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician days Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that linitated events Due to (or as a consequence of): Examiner death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): .O. Box 68760 Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 2 No 9□Unknown 9 Unknown م signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 L Unknown certificate has been s rector, page 2 should Be Completed Atrial Fibrillation, Osteoporosis, Lumbar Stenosis, 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Hypertension autopsy performed? Yes 2 No 1□ Yes Physician: 25. Was case referred to medical examiner? director 26. Place of Death Check onl one Other: 4 🛭 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After or Attending 1X Natural 5 Pending investigation Injury ospital c.
4 hours after dea.
~al Director: Afte 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a' To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and itle of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

Anuradha Arun, MD

31. Date filed (Month, Day, Year) FEB 2 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



un

**ORIGINAL** 

D57630

10301 Georgia Avenue, #209, Silver Spring, MD 20902

February 28, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For Amend#7 per FH State of Mary Registrar 2/27/08 AACO HEALTH DEPT CMH Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month February <sup>Day</sup>22 2008 **Physician** 10:30AM Virginia Smith /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Nursing Center Arnold Anne Arundel 8. Date of Birth (Month, Day, Feb 15 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 92 -91 Yrs. 214-20-4495 1 □ M 2 7 F 1916 Maryland Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10h County 10a State items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 X No Glen Burnie Maryland Anne Arundel Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 328 Woodleaf Ct. 21061 USA death by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, f Health and Mental Hygiene. Item 27 Is marked other than "natural", or item other traumatic event, <u>the Medical Examiner</u> I Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. fX☐ Never Married 2☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: **Black** 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) International Elementary/Secondary (0-12) College (1-4or 5+) 7th 0 Ladies Garment Clothing Factory Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James E. Smith Carolina Pratt ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Connie Maynard(Great Niece) 328 Woodleaf Ct. Glen Burnie, Md. 21061 20b. Blace Pippolitica (Name of Cernetery Pierratory or other place)
Memorial Park Date 20c. Location - City or Town, State 20a Method of Disposition Department of H Important: If ite any Injury or ot 1 XBurial 2 □ Cremation 3 □ Removal from State 2-26-08 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) Millame Reades of Acide ons Mortuary, P.A. 21. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. 21401 4, Nease MO0 483 Jarry 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ears Physician advanced disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinial at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consenuence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical | IF FEMALE 23c. if yes, outcome pf pregnency 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon Month Day Year 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2 No 1□ Yes Hospital or Attending Physician: 25. Was case referred medical funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mann of Death 28b. Time of 28d. Describe how injury occurred 1 Matural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Medical 29a. Certifier 1 Defertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of oetifier 29c. License number 29d. Date signed (Month, Day, Year) 10. Name and address of pe State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Mary Virginia Spear 26 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dorchester General Hospital Cambridge Dorchester | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | April 2, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign <sup>Year)</sup>942 **Funeral** 1 □ M 2 🗙 F Maryland 213-40-5956 65 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at Dorchester Cambridge 1 X Yes 2 ☐ No MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21613 909 Race Street USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🏖 No Specify. white 2 Specify: 3 → Vidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) housekeeper nursing home 12 Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Henry Goodwin Mary Tennison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Windsor 3016 Steamer Run Road, Cambridge, MD 21613 p.r. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park 3/3/08 Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) normonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes → No 9 ☐ Unknown Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ bolmonary 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 24a. Was an has autopsy performed? this certificate 2KONo To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 1 Tyes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: after death. Director: After 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral L f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

FEB 1

DHMH 17 Rev 1/2001

Cambridge

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 12:05 A M Wend Geraldine June Siedling HW8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 18 Fairview Avenue Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 □ M 2 □ X E 214-10-3691 Director 88 7-12-1919 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director MID Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18 Fairview · death v Avenue 21701 USA 14. Bace - American Indian. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: à 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 Is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mamie Gilbert William Firestone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2596 Bear Den Rd Frederick, MD 21701 Daugh. Treva D. Siedling 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 Removal from State Injury o 3-13-2008 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cem 21. Signature of Funeral Service Lide 22. Name and Address of Facility Keeney & Basford P.A.any. lan 106 East Church St Frederick, MD 21701 M01176 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Stroke do disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gauss Unious that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed and burial-tran Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical the as attending IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? Year Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9☐Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe certificate 1□ Yes 2-No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA lo the mostrum.
within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar (Check only one)

10 31. Date filed (Month, Day,

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

4

32. Registrar's Signature

DHMH 17 Rev 1/2001

To the

**ORIGINAL** 

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

08-01878 Randall C. Sines Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

indali C. Sipe		State of Maryland / Department of F		al Hygiene Reg	200	8 0826
Physici	an/	Registrar  1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death 1531 hrs
edical Exami ∖ু	iner	Randall Charles Sipes  4a. Facility Name (if not institution, give street and number)  4b.	City, Town, or Location of I	Month 1 March 6, 20	4c. County of Death	1531 NIS
			Hagerstown		Washington	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 2 Months Days Hours	24Hrs. 8. Date of Birth Min.	(MM/DD/YYYY) 9. Birth Foreign	place (State or
Director		169–64–9414 <sup>1</sup> X <sup>M</sup> <sup>2</sup> F 27 <sup>Yrs.</sup>	Months Days Hours	May 15,	Cour	<sup>ntry)</sup> PA
my		Usual Residence of Decedent  10a. State  10b. County  110c. City, Town or Location	1			10d. Inside City Limits
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ne Maryland or 28a-f show any Ifed at once.	Director		10f. Zip Code	100	g. Citizen of What Count	ry?
h the l 3a or otifie		733 Indian Grave Road	17267		JSA	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath is and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	uneral	1 Never Married 2 Married Armed Forces? If Yes	Decedent of Hispanic Origin , specify Cuban, Mexican, P		14. Race - Americ White, etc.	an Indian, Black,
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5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner.	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's	Usual Occupation (Give kint of working life, DO NOT us		16b. Kind of Business/In	
36 n 72 h nan "n ical E:	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)				
-003 d withingree.	mo	12 Labore		Name (First, Middle, Ma	Paving aiden Surname)	
21215-0036 unld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be (	Robert C. Sipes	Joann	n Lynn Flow	ers	
21 should nd Mer is man	2	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing A	Address (Street and Number	er or Rural Route Numb	per, City or Town, State,	Zip Code)
and 2 s ealth a em 27		Robert C. Sipes/Father 733 In  20a. Method of Disposition 20b. Place of Disposition	dian Grave RI on (Name of cemetery,	) Warfordsb Date	11rg PA 172 20c. Location - City or 1	267 Fown, State
MOFE Pages 1: nent of H ant: If it		1 X Burial 2 Cremation 3 Removal from State crematory or othe		02/11/00		D3
Baltimore, MD 21215-00: permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other injury or other traumatic event, the Med	Ι×	4 Dogation 5 Other Specify Amaranth B 21. Signature of Funeral Service Licensite 22. Na:	rethren I ome and Address of Facility		Warfordsbur	rg, PA
Dep Dep Injury	9 72	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the				21750-0368
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	mode of dying, such as car	diac of respiratory arres	st, shock, or heart	Between Onset and
xaminer	0 6	Immediate Cause (Final disease or condition resulting in death)  a Multiple Gunshot Wounds  Due to (or as a consequence of):		N		Death
		Sequentially list conditions, b.				
	iner	if any, leading to immediate Due to (or as a consequence of):				
ed Isit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		<u>-</u>		
Vital Records, P.O. Box 68760, hysician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and I director, page 2 should be detached for use as the burial - transit	cal	d. UNPENDED AMENDED	<u>-</u> -			
60, ate be ohysicia	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
687 certific nding p	ian/	past 12 months?	_	oregnancy	Month D	ay Year
Box 687 death certifice the attending p	Physician/	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Othe	er (Specify)	222		
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Sorc law rea has be	Completed		<del></del>	autops perform	sy prior to c	ompletion of cause of
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of Vital Records, P.O. ng Physician: The law requires that the three this certificate has been signed by meral director, page 2 should be detach	o Be	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpatient			Residence 6 Other	
of Ving Phy	-	27. Manner of Death 28a. Date of Injury 28b. Time of Inj		Subject shot	ow injury occurred	
sion ttendi death. ctor: y the f	atio	2 Accident Investigation	1 Yes 2 V	No ,		
Division ratending after death.	Certification:	3 Suicide 6 Could not be determined (Specify) Major Road / Highway	tactory, office building, etc.	or Town, St	treet and Number or Ru ate) Indian Springs Road,	
Division of Vital To the Hospital or Attending Physician: within 24 hours after detach To the Funeral Director: After this certil completely filled in by the funeral director		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred	ed at the time, date and place	e, and due to the cause	e(s) and manner as state	ed.
Fo the vithin Fo the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.		urred at the time, date a		
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Mor March 7, 2008	nth, Day,Year)
		30. Name and address of person who completed cause of death (Item 23a)	3.0.IVI.E.			
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OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

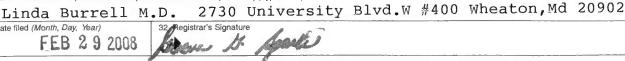
		1 - For State Registrar  1. Decedent's Name (First, Middle,	, Last)	(	Certificate of L	Death	Reg. N		3. Time of Death
Physicia /Medica	_		ith				Month D February	26, Year 200	08 1:06 p <sup>M</sup>
Examine		4a. Facility Name (If not institution,		)	4b. City, Town, or		4	c. County of Deat	
		Suburban Hospi  5. Social Security Number		ge (In yrs. last birth	Bethesda	If Under 24 Hrs.	8. Date of Birth		tgomery
uneral Director		579-40-5589 Usual Residence of Decedent	1 □ M <b>2(3</b> F	80 Y	Months Days	Hours Min.	(Month, Day, Yea	r) Co .927 Wash	hplace (State or Foreign untry) nington, DC
at		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
a-f st tified	ctor	Maryland	Montgo	mery	Silver Sp	ring			1 □Yes 2 🔣 No
or 28	Director	10e. Street and Number			10f. Zip Code		10g. C	Citizen of What Co	untry?
s 23a nust l		3215 South L				20906	nife. Van au Na	USA 14. Race - Ame	rican Indian
al", o	by Funeral	11. Marital Status 1 □ Never Married <b>2€M</b> Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' ed 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	? No	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		Rican, etc.)	Black, Whit	
natur Jical I	eted	15. Decedent' (Specify only highes.	's Education	16a. D	Decedent's Usual Occupa Give kind of work done of life. DO NOT use retired	ition Juring most of worki	16b.	Kind of Business	Industry
than "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	ife. DO NOT use retired, ceptionist	)		ırniture	Compone
is marked other than raumatic event, the Me		17. Father's Name (First, Middle, L	Last)	, Ke	ceptionist	18. Mother's Name	(First, Middle, Maide		Company
c eve	To Be	William Joseph To	*		ļ.	Cvelyn Ca	therine Pe	rkins	
marl	ř	19a. Informant's Name/Relationsh	nip (Type. Print)	19b. I	Mailing Address (Street a	and Number or Rura	al Route Number, City	or Town, State, 2	Zip Code) 2090
2.5		James Rosser S	mith/Husban	đ	3215 S. Le	isure Wo	rld Blvd.	#1E, Sil	ver Spring
r other		20a. Method of Disposition	0 Domewal from State	20b. Place of I cemetery	Disposition (Name of crematory or other place	9)		Location - City or	Town, State
Important: If item any Injury or othe once.		t⊟ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other ( <i>Sp</i>		Gate of	Heaven Cem		ch 1, 2008   Si	lver Spr	ing,Maryla
Important: I any Injury o once.		21. Signature of Funeral Service L	Licensee	`	22. Name and Addres	s of Facility Collins			
- 20		Lauro	, 5 De		500 Univers	ity Blvd	., W., Sil	ver Spri	
		23a. Part1. Enter the disease, or shock, or heart ailure. List of	complications that cause only one cause on each l	ed the eath. Do no line.	t enter the mode of dying	g, such as cardiac	or respiratory arrest,	31.	Approximate Interval Between Onset and Death
sician		Immediate Cause (Final disease or condition resulting in death)	_a. Coron	ary Arter	y Disease				years
edical miner		resulting in death)	Due to (or as	s a consequence of	):				_
3.5	-	Sequentially list conditions,	b. Ischer	mic Cardi	omyopathy				years
tusit	Examiner	Sequentially list conditions, in any leading to the clast cause. Enter Underlying Cause (Disease or injury that initiated events are ultimated to the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the conditions of the co	Acute	Renal Fa	ilura				davs
n and ial-tra	Еха	resulting in death) Last		s a consequence of			.,		uays
	edical		d						
D gg	-	IE EEMALE:	T						
ned by the attending detached for use	ysician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e pf pregnancy 2 □ Fetal death at time of death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of de Month	livery Day Year
deta	y Phy	Part II. Other significant condition	ons contributing to death	but not resulting in t	the underlying cause give	en in Part I.	23e. Did tobacc	o use contribute t	the cause of death?
ig pa	d by						1 ☐ Yes	2 No 3 P	robably 4XIUnknown
	Completed						24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
		OF Man age				00.00	1⊡ Yes 2 <b>5</b> ⊡		2 □ No
recto	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	ient 2 DER/Outr	patient 3 DOA Othe	pr	n <i>(Check only one)</i>	6 □Othor (Co.	ncifu)
÷ @	$\vdash$	27. Manner of Death	28a. Date of In	jury 28b. Ti	me of 28c. Injury		me 5 ☐ Residence 28d. Describe how in		iony)
e fine	ation	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investig		<i>ay rear)</i> Inj		(? Yes 2 ☐ No			
Director:	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	inad   Zoe, Flace of II	njury - At home, farr etc. <i>(Specify)</i>	n, street, factory, office		28f. Location (Street City or Town, St	and Number or Rate)	ural Route Number,
- 73	S	29a. Certifier 1 Certifyin (Check only one) 2 Medical I	g Physician: To the bes Examiner: On the basis and manner s	of examination and	death occurred at the tin or investigation, in my o	ne, date and place, pinion, death occur	and due to the cause red at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
e Funeral	dice				29c. License	number	29d	Date signed (Mon	th Day Voar
he Funer pletely fil	Medical	29b. Signature and title of certifier			250. Licerise	riumber			
To the Funeral completely filled	Medica				0413			B 27,	
To the Funeral completely filled	Medica	29b. Signature and title of certifier	who completed cause of		0413	//	FE	8 27,	

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) FEB 2 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title, of certifier



29c. License number

D35996

29d. Date signed (Month, Day, Year)

Feb. 28, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per fh 9877 3-18-08 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Year FEBRUARY /Medical Ε. SHIBE 2008 1:30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SUMMERVILLE ASSISTED LIVING POTOMAC MONTGOMERY Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 21 F Director 493-34-9591 JUNE 6, 1922 POLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MARYLAND MONTGOMERY POTOMAC Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11215 SEVEN LOCKS ROAD Funeral 20854 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No WHITE Specify. þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 SECRETARY AERONAUTICS 18. Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) Maiden Surname) Be ZISMAN EISENBERG KAYLA ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RABBI MARK RAPHAEL/GUARDIAN 9915 APPLE RIDGE RD, GAITHERSBURG, MARYLAND 20886 20b. Place of Disposition (Name of Charles) GARDEN OF REMEMBRANCE MEMORIAL PARK 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 02/28/2008 CLARKSBURG, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC CHROCEN 1091 ROCKVILLE PIKE, ROCKVILLE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** GASTROINTESTINAL BLEEDING disease or condition resulting in death) 45 DAYS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ADVANCED DEMENTIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) LIVING Hospital: Certification: To 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 After this

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: within 24 hours after death To the Funeral Director: filled in by the

1 X Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

and manner stated.

5 Pending investigation

6 ☐ Could not be

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number D0061382

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Yes 2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

FEBRUARY 27, 2008

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. SHAMA R. MITTAL, 14816 PHYSICIANS LANE, SUITE 152, ROCKVILLE, MARYLAND 20850 31. Date filed (Month, Day, Year)

State Registrar

Medical



Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 2235 2008 March Herman H. Twigg /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner General borchester Cambridge If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, July 10, 9. Birthplace (State or Foreign Country) Mary Land **Funeral** Days Hours Min. 1**☑**M 2□F 203.10.6676 88 1919 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Marvland Dorchester Fishing Creek 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2743 Hoopers Island Road 21634 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ ¥6s 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. . Pages 1 and 2 should be filed within 72 hours after iment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or iten 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Completed by Specify: 3 ₩idowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Harley Davidson Laborer Motorcvcle 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stephen M. Twigg Della Lewis ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permil. Pages 1 and 2 to Depar ment of Health ar Imporant: If item 27 is any ir jury or other trau David Twigg/Son 2601 Old House Point Rd., Fishing Creek, MD Ballimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 3.14.2008 Yoe Union Cemetery Yoe, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Curran-Bromwell Funeral Home, P.A. 21. Signature of Funeral Service Licensee Curran-Bromwell Funeral Home 308 High St., Cambridge, MD 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** 2 day /Medical Examiner Preumonia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown ionzogath. obstructive 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Type II autopsy performed? Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No neral Director: A filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral [ 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Mark

31. Date filed (Month, Day, Year)

Ma

DHMH 17 Rev 1/2001

1041

ORIGINAL

408

J.M

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** THOMPSON Year ELIZABETH 06.10 AM 28 H 2008 FEB /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greater Laurel Health & Rehab. Prince George's Laurel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗓 F Months Sept 10, 1920 North Carolina Director 219-14-7130 87 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified Director 1 ☐ Yes 2 No Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò event, the Medical Examiner must be 20707 USA 14200 Laurel Park Drive or items 23a within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Specify:White 1 ☐ Yes 2X No Specify: δ 3 Widowed 4 Divorced Year or Dates: "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) Coilege (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than 3 Accountant Towing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret McDougall Seawell C. Norman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra 4230 Kenny Street Beltsville, MD 20705 Diana P. Owens/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory | 02/29/08 Beltsville, MD Going Home Cremation Service P.O. Box 784 21. Signature of Funeffal Service Licenses Ne Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DISEASE rears disease or condition resulting in death) CORONDRY ARTERY /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician Physician/Medical the attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed by details Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MIDDA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has by page 2 s autopsy 2 No certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 2 After the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after dear To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital

P.0. Division or Vital Records,

Box 68760,

Baltimore, Maryland 21215-0036

100

State Registrar 31. Date filed (Month, Day, Year)

MAR 03

29b. Signature and title of certifier

29a. Certifier

(Check only one)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Raistrar's Signature

Bowie

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 0053411

Jagdish C Shesadni

29d. Date signed (Month, Day, Year)

2008

		•	For State Registrar	State of Marylan		rtificate of De			iene eg. No.2 () () ()	08274
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Day Year	3. Time of Death
	/Medic Examin		Barney M. Versel  4a. Facility Name (If not institution, give so	reet and number)		4b. City, Town, or Lo		February	7 22, 2008 4c. County of Dear	
L	Examin	er	Montgomery General			01ney			Montgomen	cy
ı	Funeral Director		5. Social Security Number 6. Sex 111-12-7533 1√2	7. Age ( <i>In yrs. i</i>	ast birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 20	Year) 9. Bird Co. New	thplace (State or Foreign buntry) York
	death with the Maryland ms 23a or 28a-f show r must be notified at		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	e Mar 3a-f sl	Director	MD Montgome	ry	Silver	Spring				1 ☑ Yes 2 ☐ No
	vith th	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	ountry?
	sath v	eral	3701 International	Drive #723  2. Was Decedent Ever in U.	S 13 V	20906	anic Origin? (Spe	cify Ves or No-	U.S.A.	erican Indian.
136	72 hours after death with the Marylan 'natural', or Items 23a or 28a-f show dical Examiner must be notified at	by Funeral I	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	Armed Forces?  1 ⊠Yes 2 □ No Arm If Yes, Give Year or Dates: WW2	ıy	Nas Decedent of Hisp f Yes, specify Cuban, I□Yes 2점 No	Mexican, Puerto  Specify:	Rican, etc.)	Black, Whit	
5-0036	72 hou	ted	15. Decedent's Educ	ation	16a. Deced	lent's Usual Occupati	ion ring most of worki	na 1	16b. Kind of Business	/Industry
	be filed within 72 hc tal Hygiene. d other than "natu event, the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. I	OO NOT use retired)			II C. Dont	of Defense
N D	filed v Hygie other i	ပ္ပ	17. Father's Name (First, Middle, Last)	5+	Procu	rement Spe			Maiden Surname)	or Defense
land		To Be	Arthur Verschleiss	er			Gertrud	e Balaba	an	
Mary	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Typ	*	1	•			r, City or Town, State,	Zip Code)
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Mark J. Versel - S			ersey Lane				
Baltimore,	e = 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Re	emoval from State		sition (Name of natory or other place)	1	acco	20c. Location - City or	
	permit. Pag Department important; any Injury once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License		25	n Nat'l Ce	of Facility		Arlington,	Virginia
g	Depa impo any		thomald C	Da	Ed	ward Sagel	l Funera.	l Direct	ion, Inc. 1e, MD 208	352
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death e cause on each line. A+hLvoscl. Due to (or as a consequence)	erohi	er the mode of dying,	such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
ou,	ificate be executed g physician and as the burial-transit	il Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)						
<b>68/6</b> 0,		edical	d							
O. Box t	The law requires that the death certif te has been signed by the attending age 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome pf pregna 1 □Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	elivery Day Year
ds, F.	uires that signed by Id be deta	þ	Part II. Other significant conditions con  Tschemic Car			nderlying cause given	in Part I.	23e. Did to	bacco use contribute t es 2  No 3  F	o the cause of death?
Vital Hecords,	las las	Completed			J			24a. Was a autop perfor	med2   death?	utopsy findings available completion of cause of
<u>ra</u>		BeC	25. Was case referred to medical examiner?				26. Place of Deat		<del>-</del>	
o 	Physic this ce al direc	To	1 Yes 2 No		ER/Outpatier		4 LI Nursing Ho		ence 6 □Other (Spe	ecify)
	ding Ph n. After th funeral		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work?	at es 2 □ No	28d. Describe h	ow injury occurred	
DIVISION	ten leatl tor: the	Certification:	Accident investigation  3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, str y)			28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edical Ce		ician: To the best of my kno ner: On the basis of examina and manner stated.						
	To th Within To th comp	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed (Mor	oth, Day, Year)
)	12		Myllud	des		D00:	28429	7	February 2	2,2008
			Phyllis Nicholson	mpleted cause of death (Iten	n 23a) (Type,	lip Orive	Olney 1	naryla	February 2 nd 208 32	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 9 2008	82. Registrar's Signa	ature	E)	·	•		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day February 24, 2008 0901 hrs **Medical Examiner** Donald A. Warren 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Edgewater Anne Arundel 4079 Cadle Creek Road 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Director 146-36-6759 Country) New Jerse 12/05/1945 62 1X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a. State 10b County 1 Yes 2 X No 23a or 28a-f show notified at once, Edgewater Marvland Anne Arundel Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 4079 Cadle Creek Rd. 21037 USA 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12. Was Decedent Ever in U.S traumatic event, the Medic I Examiner must be White etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 X Yes White If Yes, Give Year Viet Nam Yes 2 X No specify: Specify: 3 Widowed 4 X Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 0wner Boat Restoration 12th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillian Horton Arthur N. Warren Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 951 Valentine Rd., Burlington, NJ 08016 Virginia M. Roughton/ Sister 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 X Cremation 3 Removal from State 2/27/08 Edgewater, MD Kalas Crematory Dopalon 5 Other Specify. 5 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 rt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and ailure. List only one cause on each line. /Medical Death a Contact Gunshot Wound of Head Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED the attending physician ed for use as the burial the Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death signed by the attending be detached for use as I past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed director, page 2 should 24b. Were autopsy findings available 24a. Was an peen prior to completion of cause of autopsy certificate has performed? death? Yes 2 Nα Yes 2 V No 26.Place of Death (Check only one) Division of Vital 25. Was case referred to medical Be examiner? Residence 6 V Other: Scene Other: Nursing Home 5 Inpatient 2 ER/Outpatient this 1 🗸 Yes ٩ No 28c. Injury at Work? 28d. Describe how injury occurred the funeral 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury After 27. Manner of Death Subject shot self FOUND: 1 Natural Yes 2 V No death Pending Feb 24, 2008 To the Funeral Director: completely filled in by the 0000 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide Could not be or Town, State) 4079 Cadle Creek Road, Edgewater, MD determined (Specify) Woods Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ga Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗸 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 25, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD strar's Signature

Registra DHMH 17 Rev 1/2001

**OCME 2006** 

State

32. Re

31. Date filed (Month, Day, Year)

2. Date of Death

Month

3. Time of Death

6. M

3

Birthplace (State or Foreign Country)

10d. Inside City Limits

1X Yes 2 No

Virginia

Year

2008

Montgomery

Race - American Indian, Black, White, etc.

Government

Specify:

**Black** 

Approximate Interval Between Onset and Death

23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes 2 No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who comp

1. Decedent's Name (First, Middle, Last)

Catherine

Ruth

West

**Physician** 

32. Registrar's Signature

and manner stated.

To the

Medical

m 23a) (Type, Print)

29c. License number

DOOK 362

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Director 5//-40-0842 83 Tis. July Usual Residence of Decedent	Day Year
/Medical Examiner  Willietta Woodson  4a. Facility Name (If not institution, give street and number)  Millennium of Forestville  Funeral Director  5. Social Security Number  5. Social Security Number  6. Sex 1 Months Days Hours Min. July  Usual Residence of Decedent  February  4b. City, Town, or Location of Death  Forestville  Forestville  8. Date of (Months) Days Hours Min. July	1ary 23, 2008 8:45 A <sup>M</sup> 4c. County of Death
4a. Facility Name (If not institution, give street and number)  Millennium of Forestville  Funeral Director  Millennium of Forestville  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  6. Sex  1 M 2 M 2 M 5  83 Yrs.  4b. City, Town, or Location of Death  Forestville  Forestville  (Month)  Months Days Hours Min.  July  Usual Residence of Decedent	4c. County of Death
Funeral Director  5. Social Security Number 6. Sex 1 Months Days Hours Min. Security Number 577–40–0842  Usual Residence of Decedent  6. Sex 1 Months Days Hours Min. Months Days Hours Min. July	Prince George's
Director  577-40-0842  Usual Residence of Decedent  1 M 2 DF 83  Yrs. Months Days Hours Min. (Month July)	
Director 577-40-0842 83 Yrs. July Usual Residence of Decedent	
	25, 1924 Virginia
to ≱	10d. Inside City Limits
day of the short o	17€ 2 □ No
Maryland Prince George's Oxon Hill  10e. Street and Number  10f. Zip Code	10g. Citizen of What Country?
5201 Wheeler Road 20745	,
Set to the set of the	United States
Armed Forces? If Yes, specify Cuban, Mexican, Puèrio Rican, etc.  1	
The politic part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part o	Specify: Black
To be a first of the first of t	16b. Kind of Business/Industry
(Specify only highest grade completed)    Give kind of work done during most of working life. DO NOT use retired)    Give kind of work done during most of working life. DO NOT use retired)	
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	ddle, Maiden Surname)
10a. State 10b. County 10c. City, Town or Location 10c. Ci	with a City of Tarrior City Tarrior
Peggy L. Jones - Cousin 5201 Wheeler Road Oxon Hi	
20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	20c. Location - City or Town, State
	008 Laurel. MD
20a. Method of Disposition  1	
m ace 5	
23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or cardiac or leach line.	ry arrest, Approximate Interval Between
Physician Immediate Cause (Final disease or condition	Onset and Death
/Medical resulting in death)  Due to (or as a consequence of):	
. Sequentially list conditions b. Hypertension	
that initiated events resulting in death) Last Due to (or as a consequence of):	
Due to (or as a consequence of):    Cause Cipsease or injury that initiated events resulting in death) Last   Cause Cipsease or injury that initiated events resulting in death) Last   Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a consequence of):	
So the past 12 months?  23c. If yes, outcome pf pregnancy  1	23d. Date of delivery
The part of the pa	Month Day Year
The part of the pa	
	Did tobacco use contribute to the cause of death?
Dementia  Dementia  24a. Value of the property	☐ Yes 2☐ No 3☐ Probably 4 🛣 Unknown
A) 6 9 0 1 0 1	Vas an 24b. Were autopsy findings available prior to completion of cause of
24a. V	performed? death? es 2.XNo 1 □ Yes 2 □ No
1 To You was case referred to medical examiner?	
25. Was case referred to medical examiner?  1 Yes 2 X No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 X Nursing Home 5 F	Residence 6 Other (Specify)
28d. Descr 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Descr 12th 28b. Time of 28c. Injury at 28d. Descr 28	ibe how injury occurred
2 Accident investigation   M   1   Yes 2   No    1 Suicide   Could not be determined   Specific and Specific	on (Street and Number or Rural Route Number,
27. Manner of Death 1 12Natural 5   Pending investigation 3   Suicide 4   Homicide   Homicide   Sec. (Specify)   28b. Time of Injury M   28c. Injury at Work? 1   Yes 2   No   28c. Injury at Work? 1   Yes 2   No   28c. Injury at Work? 2   No   28c. Injury at Work? 2   No   28c. Injury at Work? 3   Yes 2   No   28c. Injury at Work? 3   Yes 2   No   28c. Injury at Work? 3   Yes 2   No   28c. Injury at Work? 3   Yes 2   No   28c. Injury at Work? 3   Yes 2   No   28c. Injury at Work? 3   Yes 2   No   28c. Injury at Work? 3   Yes 2   No   28c. Injury at Work? 3   Yes 2   No	Town, State)
	the cause(s) and manner as stated.
29a. Certifier 1 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and due to 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and due to 2 Medical Examiner: On the basis of examination and/or investigation.	me, date and place, and due to the cause(s)
29b. Signature and title of certifier	29d. Date signed (Month, Day, Year)
D51520	February 28, 2008
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0000
	111137
Dr. Bahram Pishdad 1328 Southern Ave, SE Washington, DC 2  State Registrar  MAR 0 3 2008  Dr. Bahram Pishdad 1328 Southern Ave, SE Washington, DC 2	0032

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Violet K. Webb February /Medical 29, 2008 4:20 A. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Solomons Nursing Center Solomons Calvert If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 7 F Director 005-14-3266 87 08-26-1920 Maine Usual Residence of Decedent 10c. City, Town or Location a or 28a-f show t be notified at 10a. State 10b. County 10d. Inside City Limits MD Director Prince George's Hyattsville 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2009 Rittenhouse Street 20782 items 23a permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must to United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No 2 Specify Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Coin Department Coin Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph King Marie Gagnon ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda Vaughn (Daughter) 21709 Goodstone Drive, Gathersburg, MD 20882 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 Removal from State Maplewood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) unknown Fairfield, Maine 21. Signature of Funeral Service Lice 22. Name and Address of Facility Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician (evaloro vera cular disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-1 Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical the as t attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Yea 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No the 9☐Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of has death? certificate 1□ Yes 3 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 425 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this nours after death.

neral Director; After this
filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Hospital Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 247611 February 29 2000 Name and address of person who completed cause of death (Item 23a) (Type, Print) RINCE PREdERICK, IID Hospital JRW. David J. HARdio MI) 31. Date filed (Month, Day, 32. Registra s Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 7 **Physician** 9:31AM Allen Lee rebruary 2008 West /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Doctor's Hospital Lanham Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 XM 2 □ F Days Director 579-46-5572 67 April 8, 1940 Washington, DC Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits iral", or Items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Director Maryland | Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6008 Sarvis Avenue 20737 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ≥ ∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1∐Yes 2∏XNo Specify þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u> Highway Engineer</u> Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clifton West ၉ Catherine Spencer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary A. West - Wife 6008 Sarvis Avenue Riverdale, MD 20737 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any Injury or c 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Mem. Cemt. 4 Donation 5 Other (Specify) Mar 4, 2008 Suitland, MD 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funer Il Service License 4001 Benning Road, NE Washington, DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleart failure. List only one cause on each line. Immediate Cause (Final isbetes disease or condition resulting in death) Due to (or as a consequence of): per TENSION Sequentially list conditions, if any, icalling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐Live birth 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an perform 2 - No Certification: To Be 26. Place of Death (Check only one)

**Physician** /Medical Examiner

'natural"

Baltimore, Maryland 21215-0036

pe f

physician and s the burial-trans as use detached page

death certificate be executed Hospital or Attending Physician: funeral director. After To the Hospina. — within 24 hours after death.

To the Funeral Director: After — maletely filled in by the fur Medical

Division or Vital Records, P.O. Box 68760

Registrar

25. Was case referred to medical examiner? 2 No 1 TYes 27. Manne of Death 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 Homicide

(Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of pertifier

5 ☐ Pending investigation 6 ☐ Could not be determined

1 Inpatient 2 ☐ R/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

1 VertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29c. License number MDD30858

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)
02/27/08

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Luck Rd., Lanham, MD 20706

31. Date filed (Month, Day, Year)

MAR 0 3 2008

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Dalumore, maryland 21213-0030
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
important: If Item 27 is marked other than "natural", or items 23a or 28a-f show
any Injury or other traumatic event, the Medical Examiner must be notified at

Physicia /Medic Examin

Funeral Director

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

	•	1 - For State Registrar			ertificate of			Reg. No.	2000	00200					
sicia		1. Decedent's Name (First, Middle, Las Hubert Lee	Atwater,	Jr.			2. Date of De Month 03	ath 13	ž608	3. Time of Death $5:00A^{M}$					
edic min	- 0	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	h	4c. County of Death  Anne Arundel							
rai or		245-54-7488	ex 7. Age	(In yrs. last birthda)	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da 03-06-1	v Year)	9. Birthpl Count	ace (State or Foreign ry) NC					
	tor	Usual Residence of Decedent  10a. State 10b. County  MD Anne Art		10c. City, Town or I	Location Burnie				10	0d. Inside City Limits 1 ☐ Yes 2√ No					
	al Direc	10e. Street and Number 1504 Charles Aver	nue		10f. Zip Code 21061	L		10g. Citiz	en of What Count						
	Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces?	ver in U.S. 13	Was Decedent of H If Yes, specify Cub		pecify Yes or No to Rican, etc.)		4. Race - America Black, White, 6 Specify: Whi	White, etc.					
	mpleted	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 1 2	ducation ade completed) College (1-4or 5+	(Giv	edent's Usual Occup re kind of work done DO NOT use retire	during most of word d)	rking		od of Business/Ind	of Defense					
e r	Se Co	17. Father's Name (First, Middle, Last)	)		2111 00111		me (First, Middle,								
Ž	70	Hubert L. Atwate		10h Ma	ding Address (Street				Crabtree City or Town, State, Zip Code)						
		19a. Informant's Name/Relationship ( Mrs. Miriam P. Atv			504 Charle				urnie, M						
		20a. Method of Disposition  1   Burial 2   XCremation 3   Removal from State  4   Donation 5   Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Chesapeake Cremation 03-16-2008   Stevensville, MD													
once.		21. Signature of Funeral Service Licer	nsee	1479	22. Name and Address 1 2nd Ave		gleton I Glen Bu			mation Srv 1061					
an al		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Approximate Interval Between Ogset and Death 4 Memily 5													
er	10	Sequentially list conditions,	b	consequence of):											
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c	consequence of):											
	edical	d.													
	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)													
	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death 1 ves 2 No 3 Probably 4 Unk													
,	Somplete	24a. Was an autopsy fin prior to completic death?  1 Yes 2 12 No 1 Yes 2 No 1 Yes 2													
	Be	25. Was case referred to medical examiner?    Other:   Ot													
	ition: To	1   Yes 2   No													
	Medical Certification:	3 Suicide 6 Could not by determined	28e. Place of injurbuilding, etc.	ry - At home, farm, s (Specify)	street, factory, office		28f. Location ( City or To		d Number or Rura )	l Route Number,					
	dical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of miner: On the basis of and manner stat	examination and/or	ath occurred at the t investigation, in my	ime, date and plac opinion, death occ	e, and due to the curred at the time	cause(s) , date and	and manner as s place, and due to	tated. the cause(s)					
	Me	29b. Signature and title of certifier	h0 h		29c. Licen	D54413 Mar 13, 2008  R St. Baltimore MD 21225									
		30. Name and address of person who		ath (Item 23a) (Typ	e, Print)	754413	b or	IVU	W 131	2100					
Cto	to.	Young J.	Lee 3	r's Signature	lanover	L St.	Balli	mor	e mo	4225					
Sta istr		31. Date filed (Month, Day, Year) MAR 1 4 200	18	1 An	معمد										

20

Registrar

State

31. Date filed (Month, Day, Year)

MAR 1 4 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State	of Maryla		artment of F rtificate of			giene 2	008	08282		
Ü	Physicia	an	1. Decedent's Name (First, Middle		Roh	1 ( )	<u> </u>	, , , , , , , , , , , , , , , , , , , ,	2. Date of Dea	ath Day	Year	3. Time of Death		
ou Birke	/Medic	al	ANNA  4a. Facility Name (If not institution			73 1-1	4b. City, Town, o	r Location of Death	MARCH		2008 ty of Death	12.45M		
	EXAMINI	ıçı	Genesis Health Ca		,		Severna F				Arundel	:		
	Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Year)	9. Birthp	lace (State or Foreign		
b	Director		212.74.7849 Usual Residence of Decedent	1□ M 2□F	100	O Yrs.			July 22,	1907		Poland		
	yland Iow at		10a. State 10b. County		10c. C	City, Town or Lo	cation				1	0d. Inside City Limits		
	e Mar a-f sk tified	ctor	MD Anne Arundel Severna Park											
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?				
	eath v	eral	24 Truckhouse Rd	12 Was Dec	cedent Ever in	IIS 13	21146	ienanic Origin? (Sr	pacity Vas or No		JSA ace - Americ	SA e - American Indian,		
0	r iter	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	Armed F ied 1 ☐ Yes	orces? 121∑ No		Was Decedent of H		Rican, etc.)	ВІ	ack, White,			
2-003p	ours a	d by	3. Widowed 4 □ Divorced	If Yes, G Year or I	ive Dates:		1 □ Yes XIXINo	Specify:		Spec	Whi	te		
ה	"natu	Completed	15. Decedent (Specify only highes	s Education of grade completed	)	16a. Deced	dent's Usual Occup kind of work done DO NOT use retired	ation during most of worl	king	16b. Kind of	Business/Ind	dustry		
V	withir iene. than the Me	dmc	Elementary/Secondary (0-12)	College	(1-4or 5+)		enaker	3)		Own	Home			
ana	e filed al Hyg other vent, i	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Nam	e (First, Middle,	Maiden Surna	ame)			
ylar	should be filed within 72 hours after death with the Maryland nof Mental Hyglene. In Hyglene. In the Medical Examiner must be notified at a matic event, the Medical Examiner must be notified at	To E	unk	Photos .				unk						
Mar	12 sh h and 7 Is m traum		19a. Informant's Name/Relations				ng Address (Street				n, State, Zip	Code)		
<u>.</u>	Healt Healt tem 2		George J. Bagrowski  20a. Method of Disposition	\$o		Place of Dispo	halet West, sition (Name of	i	Date Date	21108 20c. Location	r - City or To	wn, State		
Ē	Pages lent of nt: If i		1 ☐Burial 2 ☐Cremation 4 ☐Donation 5 ☐ Other (S			-	matorý or other plac Cemetery	i	13, 2008	Baltimo	ore. MD			
Dallillo	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if them 27 is marked other than "natural;" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee		, -	2. Name and Addre				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
0	83 = 88		K. Gregory Fink	_	M01148		426 Crain	Hwy S., G1	<u>en Burnie</u> .		51			
	8		23a. Part Enter the dise se, or shock, or heart friend. List	complications that nly one cause on	caused the de- each line.					rest,		Approximate Interval Between Onset and Death		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. HC	O (or as a conse		ENAL	FAIL	URE			NEEK		
	Examiner			Due to		DRA	TION				1	WEEK		
à	P L #	iner	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(ur as a conse	quenes of):								
	and and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a conse	EWT	IA				1	COTEARS		
0/00,	sician buria	al E			(01 40 4 001100	,440,100 01).								
00	tificate ng phy as the	ledical		0.										
Š	ath cer tendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		utcome pf preg birth 2 □ Fe		∃Ectopic pregnancy	/			ate of delive	ery Dav Year		
5	he dea the at	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Preg 9□Unki	nant at time of nown	death 5	Other (specify)				MOHEN	Day Teal		
Ļ	that the post of t		Part II. Other significant condition	ns contributing to	death but not re	esulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use co	ntribute to th	ne cause of death?		
colds,	equires en sign	ed by	DIABETES	. ME	LLIT	25			1 🗆 1	res 2 No	3 ☐ Prob	ably 4  Unknown		
מכ	law re as bee 2 sho	Completed							24a. Was		. Were auto	psy findings available mpletion of cause of		
	cate h	Com							perfo 1□ Yes	rmed? 2 No	death? 1 ☐ Yes	_		
VII.	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		75000	Oth	26. Place of Dea						
5	y Physer this eral di	5	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	of Injury	ER/Outpatien 28b. Time of	IL 3 LI DUA	Nursing He کار ک	ome 5 Resident			y)		
2	arth. or: Afte	atio	1 Natural 5 Pending investig	ation	nth, Day Year)	Injury		K? Yes 2 □ No						
<u>"</u>	or Atter de Directe	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ned Zee. Plac	e of injury - At ding, etc. (Spec	home, farm, str cify)	eet, factory, office		28f. Location (S City or Tov	Street and Nun vn, State)	nber or Rura	l Route Number,		
3	spital ours a neral D		29a. Certifier CertifyIn	g Physiclan: To th	e best of my kr	nowledge, death	occurred at the tir	me, date and place	and due to the	cause(s) and r	manner as s	tated		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 64 hours and 42 hours alter death.  To the Funneral Director: After this certificate has been signed by the attending physician and 7 completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical one)	Examiner: On the	basis of examin nner stated.	nation and/or in	vestigation, in my o	ppinion, death occu	rred at the time,	date and place	e, and due to	the cause(s)		
	Vithi To th	Ň	29b. Signature and title of certifier	ten	M. D	)	29c. Licens	e number		29d. Date sign	ned (Month,	Day, Year)		
1	2		Pure				105	1104	216	MAKC	4 10	1006		
	2		30. Name and address of person	who completed cau	100	em 23a) (Type,	Print) D	AHA	( LEVI	BULL	NI	r MD		
γ	Sta		31. Date filed (Month, Day, Year)	321	Registrar's Sigi	nature		/		- V )		12/06		
	Registra	ar	MAR 14	2008	Distant 1	ESK. CAS	1497							

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State of Maryland / Department of Health and Mental Hygiene

2008 08283

			nistrar									Reg. No.	No.				
edic	Physicia al Examir	n/ 1 ner	. Decedent's Name (First, Middle TAVON D. BU	JRKS							2. Date of Death Month Day Year March 11, 2008  4c. County of Death						
		4	<ol> <li>Facility Name (if not institution 2500 Block of Edgecomment)</li> </ol>		uth		4b. City, Tow Baltimo										
	Funeral Director	5	Social Security Number 213–33–7220	6. Sex	7. Age (In yrs. Ia			) Year Days	If Under Hours	24Hrs. Min.		3/1991	Fore	Birthplace (State or eign MARYLAND Country)			
	nd show any ce.	1	Usual Residence of Decedent  10a. State											10d. Inside City Limits 1 Yes 2 No			
	th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number									10g. Citizen o USA	f What Co	untry?			
	ter death with to receive the constant of the	Funeral	11. Marital Status 1 X Never Married 2 N 3 Widowed 4 Di	S. 13. W If`	as Decedent Yes, specify (	Cuban, I	Mexican,	n? ( Spe Puerto F	cify Yes or I tican, etc.)		White, etc. $\mathrm{BL}$	arican Indian, Black,					
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner.	eted by	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12TH	ecify only highest gr		, v	nt's Usual Oc nost of workin	ng life. [	DO NOT u	ise retire	ed)	16b. Kind o	STUD				
215-0036	e filed with tal Hygiene ked other i	Be Comple	17. Father's Name (First, Middle ROGER L. B					1	MAU	REEN	E. G						
MD 21	12 should the and Mer 27 is mar umatic even	٢	19a. Informant's Name/Relation  MAUREEN E. GR		ER	1715	STELI	LA C	OURT			AK, MD	2120				
Raltimore	Pages I and lent of Heal int: If item ir other tra		20a. Method of Disposition  1 X Burial 2 Cremation  4 Donation 5 Other		from State KI	Place of Dispo crematory or o NG MEM	other place) IORIAL	PAR	K		.8/08	WINI	OSOR	MILL, MD			
Rolfi	permit. Departm Imports injury o		21. Signature of Funeral Service	e Licensee	Now	7. 4	600 L	IBER	H YT	EIGH	ITS AV	UNERAL E, BAL	rimor	21207 E, MD			
P	hysician I aminer	8 9	23a. First Enter the disease, of hitere, List only one caus Irm elline Cause (Final diseas or condition resulting in death)	se on each line. se a. Mult <b>iple (</b>	Sunshot Works a consequence of	nds	the mode of	aying, s	such as ca	ardiac or	respiratory	arrest, sriock,	or near	Between Onset and Death			
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Court (Disease or injury that initiated	iel C.	s a consequence o												
V	executed an and al - transit	al Exar	events resulting in death) Las	d	s a consequence of	of): 											
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0	res that the designed by the	by Ph	Part II. Other significant cond	ditions contributin	g to death but not	resulting in th	e underlying	cause g	given in Pa	art I.			o 3	e to the cause of death?  Probably 4 Unknown			
-	LIVISION OF VICAL RECORDS, tal or Attending Physician: The law require state death. al Director: After this certificate has been si led in by the fineral director, page 2 should the	ıeı				<u></u>					F	Vas an autopsy performed?	prior deat	e autopsy findings available to completion of cause of th? Yes 2 No			
5	Cal Rection: The certificate ector, page	S	25. Was case referred to med	ical				26.Place	of Death								
1	VICA ysicial his cer direct	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpati		OA	Other <sub>4</sub>		ng Home 5			Other: Scene			
	Off Of VI ending Physi- ath. or: After this the funeral dir	tion: T									Subject						
:	UIVISION I I ospital or Attend 24 hours after death Funeral Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 4 ✔ Homicide 1.2500 bill Could not be determined 1.2500 bill Could not be de									Location (Street and Number or Rural Route Number, City or Town, State) blk Edgecombe Circle South, Baltimore, MD					
	UIVISION OF VICEI NEW To the Bospital or Attending Physician: The within 24 hours alter death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	edical C	29a Certifier	Physician: To the Examiner:On the ba	sis of examination	edge, death or and/or invest	igation, in my	y opinio	n, death o	ccurred	d due to the at the time,	date and place	e, and due	to the cause(s)			
	F 18 F 8	Me	29b. Signature and title of cer				290		se numbe .M.E.	r		- 1	n 11, 20	(Month, Day, Year)			
	2		30. Name and address of personal Ling Li, MD Assis			<sub>em 23a)</sub> I1 Penn St	reet, Balti	more,	MD 21	201							
	J	tate	31. Date filed (Month Day, Ye	<sup>ar)</sup> 4 2008 <sup>32</sup>	2. Régistrar's Signa	atur	barke										

			For State	State of Mai	ryland		rtment of H		Mental Hy	_	2000	8 08281		
-			Registrar  1. Decedent's Name (First, Middle, Last	<i></i>		Oer	inicate or	Dealli	2. Date of D	Reg. No.		3. Time of Death		
Phys			Barbara 9	Bech tel					Month	Day 12	y Year 2e∪8	/		
/Me Exan			4a. Facility Name (If not institution, give				4b. City, Town, o	or Location of Dea			County of Dea			
LAGI	111116		Genesis Permin	Barkway			Parku	14			Bal4-			
Funer	al		Social Security Number     6. Se			ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Mir	8. Date of B	irth	9. Bir	thplace (State or Foreign		
Directo	or		210 20 2014	□ M 2 □ <b>X</b> F   <b>7</b> 6	)	Yrs.	WOTHITS Days	Hours Will	November	4, 19	931 West	Virginia		
pus *		ŀ	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Loc	ation					10d. Inside City Limits		
faryla sho ed at		ا ة	Maryland N/A		-	ltimore						1 □Yes 2 □ No		
the N 28a-		ec t	10e. Street and Number			r orning G	10f. Zip Code			10g. Citi	izen of What Co			
a or	1	Funeral Director	3500 Woodring Avenue	21234			. og. o	USA	January.					
death ms 2:		Jera	11. Marital Status	12. Was Decedent Ev Armed Forces?	6. 13. W		Hispanic Origin? ( an, Mexican, Pue	0-	14. Race - American Indian,					
after after niner	1		1 ☐ Never Married 2 ☐ Married					rto Rican, etc.)		Black, White, etc.				
ours aurair, c	:	چ	3 ₩ Widowed 4 Divorced		1	□Yes 2√ No	Specify:		Specify: White					
72 h 72 h 72 h	1.	Completed	15. Decedent's Edu (Specify only highest grad	- 1	(Give k	ent's Usual Occup	during most of we	orking	16b. Ki	/Industry				
vithin han within		ם	Elementary/Secondary (0-12) College (1-4or 5+)				O NOT use retire			D:4	to Aid	1		
Hygie nt, th		3	17. Father's Name (First, Middle, Last)			FIIQI	macy Techr		ame (First, Middle		te Aid			
d be ental	- 1	lo Be	Parker Ingram					Cleo He		.,	,			
shoul nd M	-	-	19a. Informant's Name/Relationship (T)	/pe. Print)		19b. Mailing	Address (Street	and Number or F		ber, City o	or Town, State, a	Zip Code)		
ite, INTAILY INTAILY ZITIONOSO stand 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at			Steven Jackson/ Son					Avenue E				_		
SS 1 a soft He literal rothe		-	20a. Method of Disposition		20b. Pl	ace of Dispos	ition (Name of atory or other pla	ce)	Date	20c. Lo	ocation - City or	Town, State		
Page ment ant: M			1 ☐ Burial 2 ဩ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)				viće Corp.		4/08	Towso	on Maryla	nd		
partification of the permit. Pages 1 and 2 Department of Health Important: If Item 27 I any Injury or other tra	ouce.		21. Signature of Funeral Service Licens	ee	1	22.	Name and Addre	ess of Facility						
7 70 E #	ā		Chustina &	. Nutter		53	5 Harford	tuck Inc Road Bal	timore Mar	ryland	1_21214			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the ne cause on each line	he death.	. Do not ente	r the mode of dyi	ng, such as cardia	ac or respiratory	arrest,		Approximate Interval Between Onset and Death		
Physicia			Immediate Cause (Final disease or condition resulting in death)	a. Preumon	ck							days		
/Medica			Tosailing in actain)	Due to (or as a	consequ	ence of):						1		
	8	<u>-</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to or as a		ence of):						months		
p / by isu	7	Examiner	cause. Enter Underlying Cause Unsease or injury that initiated events											
exect n and ial-tra		Exal	resulting in death) Last	c. Denon do Due to (or as a		ence of):								
icate be executed physician and a the burial-transit		dical		d										
rtificat ng phr as th		Jed I												
leath certific attending p		IF FEMALE:   23c. If yes, outcome pf pregnancy   1								1	23d. Date of de			
e dea he at		SICE	in the past 12 months?  1 Yes 2 No  9 Unknown								Month	Day Year		
w requires that the de should be detached		F S	9 ☐ Unknown  Part II. Other significant conditions co	maribusion an algorith bus		laine in Alexandra	dautotaa aarraa atr	en in Deat	One Did	4-6		a the course of death 0		
ires the signer		2	Cal ster Core	_	not resul		denying cause giv	ren in Fan I.		<ul> <li>e. Did tobacco use contribute to the cause of death?</li> <li>1     ☐ Yes 2    ☐ No 3    ☐ Probably 4    ☐ Unknown</li> </ul>				
requiper seen seen should		ered				SIAD								
hysician: The law requires that the death certificate be executed his certificate has been signed by the attending physician and Ricctor, page 2 should be detached for use as the burial-transit		Сотрыетеа	24a. Was an autopsy performed?									utopsy findings available completion of cause of		
n: Th ficate r, pag			Tanyanged Concer						1□ Yes	2. No	death? 1 ☐ Yes	2 No		
sicial certii		o ne	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	200	D/Outpationt	all pos Oth	or:	eath (Check only					
Phy er this	- 112	- 1	27. Manner of Death	28a. Date of Injury		R/Outpatient 28b. Time of	28c. Inju	Nursing			ce 6 ☐Other (Specify)			
nding Iff.			1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury		rk?  Yes 2 ∐ No						
or Attending Ph after death. Director: After th in by the funeral		200	2 Accident 3 □ Suicide 6 □ Could not be determined 4 □ Homicide 4 □ Homicide determined 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street an City or Town, State							d Number or R	ural Route Number,			
tal or rs after ai Dir		Certification:		Dollaring, Sto.	(Specify)	,			J. John M.	Jeni, Giale	·/			
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director; p		edicar	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Exam	sician: To the best of iner: On the basis of e	my know	vledge, death	occurred at the ti	me, date and plac	ce, and due to the	e cause(s)	) and manner a	s stated. e to the cause(s)		
the hin 24 the F	1	Medi	one)	and manner state										
7 wit	4	2	29b. Signature and title of certifier	m			29c. Licens	i 29			te signed (Mon			
	- 1			+			, ( )	[]	1		11/3/6X			

Registrar

31. Date filed (Month, Day, Year)
MAR 1 4 2003 DHMH 17 Rev 1/2001

32. Registrar's signature

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Towsa

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wendx Klotsz 6701 N Charus St Suite

Wendy Kloese

08-01921 Kevin W. Bradley Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 08285 2008 Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day March 8, 2008 0715 hrs Medical Examiner Kevin W. Bradley 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex 5. Social Security Number **Funeral** oreian Months Days Hours 11-10-1967 Country) Director MD 215-96-1159 1 X M 2 F 40 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 Yes 2 X No Pasadena 28a-f shov Anne Arundel must be notified at once. death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 21122 335 Bar Harbor Road 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Mantal Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married 2 X No Yes Specify: white Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Yes 2 X No specify: 3 Widowed Divorced If Yes. Give Yeer other than "natural", þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Roland Corporation 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank R. Bradley, Jr. Sharon L. Cole event, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) important: If item 27 is n niury or other traumatic 335 Bar Harbor Road; Pasadena, MD 21122 Mrs. Aimee' Bradley / wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 3-13-2008 Elkridge, MD Meadowridge Memorial Donation 5 Other Specify 22. Name and Address of Facility Singleton Funeral & Cremation 21 Signature of Funeral Service Licensee Glen Burnie, MD 21061 2nd Ave SW; Services 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Medical Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit that the death certificate be executed Physician/Medical AMENDED 23a. 27 per ME g877 3/19/2008 amh attending physician a X UNPENDED Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy IE EEMALE 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 ✔ No 3 Probably 4 Unknown ò Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has death? performed? 2 No ✓ Yes 2 No 1 🗸 Yes certificate 26.Place of Death (Check only one) Physician: 25. Was case referred to medical Division of Vital æ Other<sub>4</sub> examiner? Hospital: Inpatient 2 ER/Outpatient 3 Residence 6 Nursing Home 5 this 1 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death To the Hospital or Attending F within 24 hours after death.
To the Funeral Director; After Certification: 1 XX Natural Yes 2 No Pending Director: 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 9, 2008 O.C.M.E. mohe 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Tasha Greenberg MD. Assistant Medical Examiner State 31. Date filed (Month, Day, Year) 32. Redistrar's Signature MAR Registra

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	ges 1 and 2 should be filed within 72 hours after death with the Maryle t of Health and Mental Hygiene. If item Z7 is marked other than "natural", or items 23a or 28a-f shou If item Z7 is marked other than "natural", or items 23a be notified at or other traumatic event, the Medical Examiner must be notified at		MARION PITTS  20a. Method of Disposition		DAI	UCHTE	20b. Pla	8674 Race of Dispo	sition (Nan	ne of	- 1	MD 20	1794 te	20c. I	_ocation - City	or Tow	vn. State	
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4	/Medical Examiner		resulting in death)		Due to	(or as a	conseque		•	-								
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-	or Attending Physicians: The law requires that the death certificate be executed birectorat. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	Examiner	that initiated events resulting in death) Last	C	Due to	(or as a	conseque	ence of):								+	<u></u>	
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	ne dea the at ned fo	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		4□Pregi 9□Urikn		me of dea		Other (sp						Month		Day	Year
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	ysician: is certifica director, I	o Be	examiner? 1 ☐ Yes 2 ☐ No		lospital: 1 🗆	Inpatient	t 2□E	R/Outpatien	it 3□ DC	A Othe					6 □Other (S	pecify)	)	
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Division	I or Atteno after death Director:	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	rmined	28e. Place build	of injury ling, etc.	y - At horr (Specify)	ne, farm, str	eet, factory	, office		28	f. Location ( City or To	Street a wn, Sta	and Number or te)	Rural	Route Nu	mber,
	pital ours a eral C		29a, Certifier 1 Certif	vina Phys	sician: To the	a hest of	my know	ledge death	occurred	at the tin	ne date a	nd place, an	d due to the	cause/	s) and manner	ae eta	ated	-
	To the Hospital c within 24 hours af To the Funeral D completely filled in	Medical	(Check only 2 Medic	al Exami	ner: On the b	pasis of e	examinatio	on and/or in	vestigation	, in my o	pinion, de	ath occurred	at the time	, date a	nd place, and	due to	the cause	(s)
	To th within To th comp	Me	29b. Signature and title of cert	ifier	1 1	/-			290	. License	e number			29d. D	ate signed (Mo	onth, D	ay, Year)	
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	1/2		30. Name and address of pers	op who co	mpleted caus	se of dea	ath (Item 2	23a) (Type,			77				, , , , ,			
			13635 BALTIMORE				2070											
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 6 ITA M **Physician** Bennett Charlene 2008 /Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner easons Hospice, Normwest Hospital Baltmore Randallstown 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Months Days Hours Min 1 ☐ M 2 🔀 F Director 220-56-3845 60 15, 1948 Ohio Jan. Usual Residence of Decedent r 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits 1 ☐ Yes 2X No **Funeral Director** Maryland Harford Rel Air death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or ? 128 Glenwood Road 21014 USA permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If frem 27 is marked other than any Injury or other traumars. 7 is marked other than "natural", or items : traumatic event, the Medical Examiner mu 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 🏖 No þ Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed ! 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Information Technology Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ Julia Frances Glins Eugene George Bennett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jenny Young / Attorney 200 South Main Street, Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 3-12-08 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** lung lancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit gg 7 law requires that the death certificate be execu Due to (or as a consequence of) Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE. 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Year Day 4□Pregnant at time of death 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? After this certificate has 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPICE ို 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? Attending 1 Natural 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No death. 2 Accident after death filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or To the Hospital of within 24 hours of To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of cert

31. Date filed (Month, Day,

ELYSE

30. Name and addr

29c. License number

00060680

750 Main Street Reisterstown MD 21136

29d. Date signed (Month, Day, Year)

and manner stated.

ss of person who completed cause of death (Item 23a) (Type, Print)

MICHELION

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month March 11, 2008 **Physician** 4:10 AM Miriam F. Bunting /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year 10/18/1924 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√3√F 83 218-14-2755 **Director** Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Exa<u>miner must be notified at</u> Director Harford Abingdon 1 ☐ Yes 2 → No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 307 Crisfield Court 21009 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health end Mental Hygiene. em 27 is marked other than "natural", or ite 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No Specify: Specify: by White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry B & O Railroad Elementary/Secondary (0-12) College (1-4or 5+) Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John R. Ford, Sr. Minna Turke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health ( Important: If Item 27 is Mary Ford / Sister in Law 307 Crisfield Court Abingdon, Maryland 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. 3/15/2008 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line. Approximate Interval Between Onget and Death Immediate Cause (Final **Physician** ardia disease or condition resulting in death) /Medical Due to ( r as a consequence of): **Examiner** potensive hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed or a consequence of): Physician/Medical Tema IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ystinidomia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Funeral Director; 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Bev 1/2001

800401

Harto

rd Road

Fallston, MD 21047

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

32. Registrar's Signature

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Year)

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	Physic /Medi		1. Decedent's Name (First, Middle, L Betty Irene B							Date of Dea Month	Day	Year 2008	3. Time of Death 6:45p M
	Exami		4a. Facility Name (If not institution, gi 5034 Hilltop		ber)	4b	. City, Town, or	Location of	f Death		4c. C	ounty of Death	re
Ì	Funeral Director		5. Social Securify Number 6. 213-24-5335		7. Age (In yrs. last bi		Under 1 Year onths Days	If Under 2 Hours	24 Hrs. 8 Min. 7	Date of Birtl (Month, Day / 13/1	930		place (State or Foreign ntry) erland, MD
	ryland how		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	wn or Location	on						10d. Inside City Limits
	r 28a-f s	Funeral Director	MD  10e. Street and Number		Balt	imore	Of. Zip Code				10g. Citize	n of What Cou	1 ▼Yes 2 No
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21215-0036	.⊆ - •	Completed	15. Decedent's E (Specify only highest g Elementary/Secondary (0-12)	ducation rade completed) College (1-	4or 5+)	(Give kind life. DO N	s Usual Occupa of work done of NOT use retired	ation furing most )	of working			of Business/In	dustry
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Maryland	thould be ind Menta marked matic ev	70 8	Jack Simpson 19a. Informant's Name/Relationship	(Type Print) 3 >	naht and 19	b Mailing Ad	ddress (Street			. Heb		Town, State, Zip	2 Code)
	and 2 s ealth an m 27 Is ner trau		Saundra Tompak		12	215 J	oppa F		pt.	D Jop	pa, N	1D 2108	35
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ( 4 ☐ Donation 5 ☐ Other (Spec		tate cemete	y Hi	ry or other plac L1s	-		/2008	Balt		Maryland
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	Physician /Medical		23d. Part1. Enter the disease, or estable, or heart failure. List only the state of	a. A	used the death. Do ch line.	lic	Lucy	g, such as	_	respiratory ar	rest,		Approximate Interval Between Onset and Death
8760, 🦟	ate be executed by a single burial-transit and he burial-transit burial-transit and burial-transit and burial-transit burial-t	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	bDue to (o	r as a consequence	e of):	V						
P.O. Box 68	Attending Physician: The law requires that the death certificate be executed roteath.  roteath.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 Live bir	ome pf pregnancy rth 2 □ Fetal deat int at time of death wn		opic pregnancy ner (specify)				23	d. Date of deliv	ery Day Year
	quires that n signed by	d by Pr	Part II. Other significant conditions	contributing to dea	ath but not resulting	in the under	lying cause give	en in Part I.		<b>S</b>	bacco uso		he cause of death?
Vital Records,	The law require sate has been signaled 2 should b	Completed							_	24a. Was autop		24b. Were auto prior to co death? 1 □ Yes	opsy findings available impletion of cause of
·Vita	ysician: The scertificate director, pag	To Be (	25. Was case referred to medical examiner? 1 ☐ Yes ② No	Hospital:	patient 2 ☐ ER/O	utpatient 3	BIT DOA Othe			Check only o		Other (Speci	Relatives WSONS HOME
Division or	ending Phys sath. or: After this the funeral dir	Certification: T	27. Manner of Teath  1 Natural 5 Pending investigatic  3 Suicide 6 Could not	28a. Date of (Month	28c. Injury Work M 1 □	28	d. Describe h			<i>yy=</i> 3.6 <b>y</b> (1074)2			
Divi	ital or Att is after de al Direct led in by t	Certific	3 ☐ Suicide 6 ☐ Could not lead to determined	Zoe. Flace	of injury - At home, f g, etc. <i>(Specify)</i>	arm, street,	factory, office		28	f. Location (S City or Tow		Number or Run	al Route Number,
	To the Hospital or Attend within 24 hours after death. To the Funeral Director: \( \) completely filled in by the f	Medical	29a. Certifier  (Check only one)  1 Certifying P  2 Medical Example:	hysician: To the bar miner: On the bar and manne	pest of my knowledg sis of examination a er stated.	ge, death oco ind/or investi	igation, in my o	pinion, dea	d place, an th occurred	d due to the l at the time,	cause(s) a date and p	nd manner as s place, and due t	stated. to the cause(s)
	with Com	M	29b. Signature and title of certifier	e Lu	Les me	5		02		3	23	signed (Month,	008.
	6		30. Name and address of person who	aV, 3		(Type, Print	ern 1	tre	, 6	Balto	1	1D =	21224.
	Sta Regist	_	31. Date filed (Month, Day, Year)  MAR 1 4	2008 32. 8	gistrar's Signature	Mos	de la						

DHMH 17 Rev 1/2001

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29a. Certifier (Check only

one)

30. Name and address

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

min

4

and manner stated.

of person who completed cause of death (tem 23a) (Type, Print)

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

Eastern Avenue, Baltimore, MD 21224

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e de la constante de la consta	Exami				aleb Ch		ain							March 10		County o	f Death	
`			4a.	Facility Name (	if not institution,	give street ar	id number)		41	b. City, Tow Olney	n, or Lo	ocation of I	Jeath			ontgon		
			12	Montgomer	y General H	lospital				If Under 1	Voor	If Under 2	24Hre	8 Date of B	rth/MM/	DD/YYYY	9. Birth	nplace (State or
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	and f shov	ō	L	MD	Montgo	mery		STIVE	Spri	10f. Zip C	ode				109. Cit	izen of Wh	nat Coun	ntry?
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	A 12.15-00505 build be filed within 72 hours after death with the Maryland Mental marked other than "natural", or items 23a or 28a-f show a icevent, the M-dical L naminer must be notified at once.						s Decedent E	ver in U.S.	13. Wa	s Decedent	of Hisp	anic Origi	n? ( <b>S</b> pe	ecify Yes or N	10-			can Indian, Black,
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	or dea	Fur				orced If Yes, Gi	Yes 2. ve Year	No No		Yes 2						Specify:		ack
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5	be fill hard Fred rked	l d		Adonye	Austin	Chambe	rlain		10h Mailin	n Address	(Stree	Cian	a INK berorF	Rural Route N	lumber,	City or To	wn, State	e, Zip Code)
5	hould hould nd Me is ma	١	2   19	9a. Informant's I "unii Ta	Name/Relations	nip (Type, Pri :1e	1()											
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	paritimore, MD 41410-000 permit, Pages 1 and 2 should be filed within 72 hours after Department of Health and Menhal Hygiene. Department of Health and Menhal Hygiene. Titem 27 is marked other than "natural", impury or other traumatic event, the M-dical L saminer.		1	Burial 2	2 Cremation	n 3 Rem	oval from Sta	ate Gate	matory or o	ther place) eaven	Cen	neter	y 3/	13/20	08 S	ilve	r Sp	ring, MD
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		┵-	2	3a. Part I. Enter	the disease, or	complication:	s that caused	the death. D	o not enter	the mode o	f dying,	such as c	ardiac o	or respiratory	arrest, s	shock, or h	eart	Between Onset and
	ysiciar		- 1	failure. List	only one cause	on each line.	chouneu											Death
	Examine		1 0	mmediate Caus or condition resu	e (Fina) disease ulting in death)	Due to	or as a cons	equence of):										
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	ician ician s certi	recto	m۱	examiner?		Hospit	al: 1 Inpa	tient 2	ER/Outpati	ent 3	DOA	Other <sub>4</sub>	Nun	sing Home		esidence		ther:
	of Vit ing Physic After this	the funeral director,	의	1 Yes 27. Manner of	2 No Death	2	8a. Date of II	njury	28b. Time	of Injury		njury at Wo	-3	28d. Des	cribe ho	w injury oc	curred	
	on of and ing	e fun	ē	1 X Natura	5 Pe	ending					-	Yes 2						Purel Pouto Number City
	Signature of the sector	by th	icat	2 Accide		vestigation build not be	28e. Place of	Injury - At ho	ome, farm, s	street, factor	ry, offic	e building,	etc.	28f. Loca or To	ition (Str own, Sta	eet and N te)	umber o	r Rural Route Number, City
	Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.  "al Director: After this certificate has been signed by	filled in by	Certification:	3 Suicide	de de	etermined	(Specify)				-			1				- total
	Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi	tely fi			Certifying  Medical E	Physician:	o the best of	my knowledg	ge, death or	ccurred at the	ne time,	, date and	place, a	and due to the	e cause( , date ar	s) and ma nd place, a	inner as and due l	to the cause(s)
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	ĭ ½ ₽	00	Me	29b. Signature	and title of ser	tifier				2		ense numb	, G1		- 1	March		
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	1				address of per		leted cause	of death (Item	1 23a)	111 Per	n Str	eet Ral	timore	e, MD 212	:01			
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			tate	31. Date filed	(Month Day, Ya	4 2008	32. <b>segis</b>	strar's Signat	F A	1000							DOME	
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ORIGINAL

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** CUMMINGS 12:40 P<sup>M</sup> EVA Μ. March 2008 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Joseph Nursing Home Baltimore Catonsville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours | Min. | 12/06/1912 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 212-05-1792 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at Baltimore Maryland Catonsville 1 ☐ Yes 2 No Director 10f. Zip Code 21228 10e. Street and Number 10g. Citizen of What Country? death with 1222 Tugwell Drive U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Examiner once. Black, White, etc 1 Tes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: Completed by 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telecommunications Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Joseph Kimmitt Regina I. Meushaw ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1471 Highland Road Winter Park Florida 32789 Gerald J. Kimmitt, Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/14/2008 Baltimore, Maryland Parkwood Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final · lune **Physician** M disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner emer Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be excepted burial-transi and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? s certificate has builtector, page 2 s performed 1 ☐ Yes 2 🗌 No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this hours after death.

meral Director; After this
y filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar 31. Date filed (Month, Day, Year) 2008

29b. Signature and title of certifie

EDMUNDE



30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

29c. License number

D34957

29d. Date signed (Month, Day, Year)

/sicia		Decedent's Name (First, Middle, I	Last)						2. Date of De		\/-	3. Time of Deat
ledic		George Jame	es Campbel	1					Month	12,200	Year 18	10:20a
amin		4a. Facility Name (If not institution, g	give street and numb	ber)		4b. City, Tow	n, or Location	n of Death			inty of Death	1
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eral		· ·	. Sex 7 1 🕅 M 2 🗆 F		. last birthday)		ays Hour	ler 24 Hrs. s Min.	8. Date of Bir (Month, Da	ay, Year)	Cot	place (State or For intry)
ctor		Usual Residence of Decedent		48 4	9yrs <sup>Yrs.</sup>				April	10,195	9 1	Md.
Ħ		10a. State 10b. County		10c. C	ity, Town or Lo	ocation						10d. Inside City Lir
Med	ctor	Md. Balt	co. Co.		Nottin	ngham					1	1 ☐ Yes 2 🗓
e not	Director	10e. Street and Number				10f. Zip Cod	de			10g. Citizen	of What Cou	intry?
att	ral	8927 Yvonne Av	renue				21236			USA	L	
any injury or other traumatic event, the Medical Examinar must be notified at once.	Funeral	11. Marital Status	12. Was Decede Armed Force	es?	J.S. 13.	Was Decedent If Yes, specify (	of Hispanic Cuban, Mexic	Origin? (Sp can, Puerto	ecify Yes or No Rican, etc.)	14. F	Race - Amer Black, White	
Bull	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	If Yes, Give			1 ☐ Yes 2 ☐	No Spec	ify:		Spe	ecify:	White
E E	ed t	15. Decedent's	Year or Date	es:	16a Dece	dent's Usual O	constion			16b Kind o	f Business/li	
Walter	Completed	(Specify only highest s	grade completed)		(Give	kind of work do DO NOT use re	one durina m	ost of work	ing			,
4	Eo	11th	College (1-4	or 5+)	Labor	rer				Const	ructio	on
, G	Be	17. Father's Name (First, Middle, La	est)				18. Mo	ther's Nam	e (First, Middle			
<u> </u>	To E	James H. Campb	ell,Sr.					Shirl	ey E. S	chleup	ner	
		19a. Informant's Name/Relationship	(Type. Print)	-	19b. Maili	ng Address (Str	reet and Nur	nber or Rur	al Route Numb	er, City or To	wn, State, Z	ip Code)
<u>.</u>		Shirley E. Ca	mpbell			7 Yvoni		nue	Notting	ham, M	d.212	36
5		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3	☐ Removal from Sta		Place of Dispo cemetery, crei	osition (Name o matory or other	f place)		Date	20c. Locatio	on - City or T	own, State
5		4 □ Donation 5 □ Other (Spec	cify)		Bayvie				-2008		altimo	
nce		21. Signature of Funeral Service Lic	censee -	10	22	2. Name and Ad	ddress of Fa					
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the burial-transit using the dical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. TESTIC				dying, such	as cardiac	or respiratory a			Interval Betwee Onset and Dea
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10:20 a.m.

MARCH 12, 2008

GEORGE CAMPBELL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year Physician march Robert L. Cregger, Sr. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1th and Rehabilition Cetter 15 et Bel HARFORD Birthplace (State or Foreign Country) If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1**X** M 2□ F Director 223-26-5545 01/28/1916 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2X No Director MD Baltimore Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. An entit of Health and Mental Hygiene. It flem 27 is marked other than "natural", or items 23a or. I any or other traumatte event, the Medical Examiner must be 1 any or other traumatte event, the Medical Examiner must be 1. 11815 Stoney Batter Road 21087 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Folces: 1 Mayes 2 □ No If Yes, Give Year or Dates: WWW II 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Completed by 3X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Motors Corp. 8 Electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Hubble Maggie Jane Cregger ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Cregger, Jr. (son) 11815 Stoney Batter Road -Kingsville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Gardens of Faith Cem. 03/14/2008 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 60 11750 Belair Road Kingsville, Maryland 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical ue to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to Cur as a consequence off. Examine burial-transit and Due to (or as a consequence of): Box 68760. physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy certificate 2/2 2 10 Division or Vital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ROBERT 1 ☐ Yes Other: /2P 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To ours after death.

neral Director; After this
filled in by the funeral di 27. Many or of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I Hospital 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29b. Signature and title th (Item 23a) (Type, Print) 5+1 30. Name and address of person

DHMH 17 Rev 1/2001

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08297 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2008 Month **Physician** March 10, 16:45 Joseph Fox Clingroth /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1930 Director June 1, 151-22-9481 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Tyes 2X No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21014 102 Nichols St. Unit C Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: <u>ک</u> Specify: 3 □ Vidowed 4 □ Divorced % 1645 Pn Maryland 21215-003 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Systems Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Lillian (nmn) Fox August Samuel Clingroth 1 and 2 should and N 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2211 Thomas Run Road, Bel Air, Maryland 21015 Laura Slade / Daughter timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2√☐ Cremation 3 Removal from State Hilltop Service Corp. 3-14-08 Towson, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 23a. Part1. Entertile disease, or complications that caused the shock, or heart failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Immediate Cause (Final disease or condition resulting in death) COPP **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Ö 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an Meningiomo.
25. Was case referred to dedical examiner? 1∐ Yes 2 No Vital the Hospital or Attending Physiclan; hin 24 hours after death. 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) linney 3. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

2008

MAR 14

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12:00 /Medical 4a. Facility Name (If not institution 4b. City, Town, or Location of Death 4c. County of Dea Examiner Baltimor ederic s Jast birthday) Social Security Number If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Director th Carolin Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f show must be notified at 1 es 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death Items Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Examiner 1 ☐ Yes 2 No "natural", or If 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify þ 3 Widowed 4 Divorced Be Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) marked other permit. Pages 1 and 2 should be filed.
Department of Health and Menter important: If item 27 is any injury or off once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street randdaugh Ter 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service License Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as x cor sequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) been signed by the s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 2 No 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No page 2 autopsy perform certificate 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 2No Other: 4 Nursing Home 1 ☐ Yes Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) this funeral 27. Manner of Deat 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred After 1 Natural (Month, Day 5 Pending investigation 1 🗌 Yes 2 No 2 Accident Director: completely filled in by the Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral 1 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier IND, NOTE, MBA ddress of person who completed cause of death (Item 23a) (Type, Print CALLETT - RAY, MD, M-34, MB

Registrar

State

31. Date filed (Month, Day, Year)

2008

08-01912 **Gregory Davis**  Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 08299

		- For State Registrar		Cer	tificate of	Death		R	eg. No.	
Physicia	n/	Decedent's Name (First	st, Middle,Last)	D				2. Date of Dea Month	ath Day Year	3. Time of Death 1830 hrs
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	н	4a. Facility Name (iffnot in Maryland Gener		treet and number)	41	Baltimore	ocation of De	ed(I)	4c. Oddiny of De	, , ,
Funeral	4	5. Social Security Number		7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Bi	rth (MM/DD/YYYY) 9.	Birthplace (State or
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any			County	10c. City,	Town or Location	on				10d. Inside City Limits
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2 hours after "natural", Examiner	희		10	or Dates: highest grade completed)	16a. Decedent	's Usual Occupation	on (Give kind	of work done	16b. Kind of Busine	
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5-0 Siled w Hygic		17. Father's Name (First,	, Middle, Last)			1	8.Mother's N	lame (First, Middle	Maiden Surname)	
2121; ould be fil Mental H marked ic event,	e B	19a. Informant's Name/R	- Har	ris	19b. Mailing	Address (Street	and Number	r or Rural Route No	umber, City or Town, S	State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shi injury or other traumatic event, the Medical Examiner must be notified at once	ř	TE RI	o i/o =	Scott	1230	5 60	co +	+ De 10)	Rato.	MD 21218
and 2 lealth tem 2	1	20a, Method of Dispositi	ion			tion (Name of cerr	netery,	Date	20c. Location - Cit	y or Town, State
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Medical vaminer	1	Immediate Cause (Final	I disease a. C	Congestive heart	failure					Death
vannitor		or condition resulting in	death) Do	ue to (or as a consequence	of):					
	<u>ا</u>	Sequentially list condition if any, leading to immed		ue to (or as a consequence	of):					
	Examiner	(Disease or injury that in	nitiated C		-f):					
ted Insit	Exa	events resulting in death	h) Last	ue to (or as a consequence	orj.					
30x 68760, death certificate be executed the attending physician and ifor use as the burial - transit	/Medical	X UNPENDED		AMENDED 23a, Pt.	II, 27 pe	er ME g877	3/27/08	amh		
60, ate be hysici	Med	IF FEMALE:		23c. If yes, outcome of pre	gnancy				23d. Date of de	
68760, certificate be nding physic se as the bur	an/I	23b. Was decedent preg past 12 months?	nant in the	1 Live birth  Pregnant at time of d	looth	tal death 3	Ectopic p	regnancy	Month	Day Year
Box e death c the atten ed for us	Physician	1 Yes 2 No 9	Unknown	g Unknown	leath 5 Ot	her (Specify)				
he t		Part II. Other significar	nt conditions	contributing to death but not	resulting in the u	underlying cause g	given in Part			ite to the cause of death?
P.O es that t igned by	d by	Hypertensic	on; renal	disease; chronic	drug use	<u> </u>		_   1 🗆 \	res 2 No 3	Probably 4 V Unknown
ords, w requir s been s should 1	Completed	(c)						24a. Wa	topsy pric	ere autopsy findings available or to completion of cause of
e law te has	dmo						-		rformed? dea s 2 ✔ No 1	ath? Yes 2 No
tal Rec ian: The certificate ector, page		25. Was case referred to						heck only one)		
of Vital Records, ng Physician: The law require this certificate has been someral director, page 2 should the page 2 should the state of the state o	To Be	examiner?	No Ho	ospital: 1 / Inpatient 2	ER/Outpatient	3 DOA	Other N	Nursing Home 5	Residence 6	Other:
n of ing Ph	n: T	27. Manner of Death		28a. Date of Injury (Month, Day, Year)	28b. Time of		ry at Work?		e how injury occurred	
ion trendi leath. tor:	atio	1 X Natural 5	Pending Investigation	n			Yes 2 N			Durch Number City
Division tal or Attendi rs after death.	Certification:	3 Suicide 6	Could not b	e 28e. Place of Injury - At	home, farm, stre	et, factory, office b	ouilding, etc.		n (Street and Number n, State)	or Rural Route Number, City
ir S ir	Cer	4 Homicide	determined	1-2-27	d - dd		ate and place	and due to the c	auca(c) and manner a	s stated
To the Howithin 24 h	edical	(Check only 1 Cer one) 2 V Med	dical Examiner:	n: To the best of my knowle On the basis of examination	and/or investiga	rred at the time, of tion, in my opinior	ate and place n, death occu	e, and due to the coursed at the time, da	ate and place, and due	e to the cause(s)
To the within 2 To the complet	Med	29b. Signature and title	of certifier	and manner stated.		29c. Licens	se number		29d. Date signed	(Month, Day, Year)
		Pat ./	) [	Pappi		O.C.	M.E.		March 8, 200	08
		30. Name and address	of person who c	ompleted cause of death (Ite	em 23a)				<u> </u>	
		Patricia Aronic	a-Pollak MD	. Assistant Medica	l Examiner	111 Penn S	treet, Balt	timore, MD 21	201	
		31. Date filed (Month, D	Day, Year)	32. Registrar's Signa	ature	-				
Regis	trar	MAR	1 4 200	38	& April	and the second				
DHMH 17 Rev 1/2	001				ORIGINA	<b>AL</b>				

		State Registrar		artment of Health and N rtificate of Death	Reg.			
Physici /Medi		1. Decedent's Name (First, Middle, Last)  Pressley Helen Davis			2. Date of Death Month	Day Year		
Examir	ner	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital		4b. City, Town, or Location of Death		Prince	ath George's	
Funeral Director		5. Social Security Number  578~32~7510  6. Sex 1 □ M 2 ■ F  7. Age (In yrs. 97)  97  Usual Residence of Decedent		If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 08/12	ear) (	rthplace (State or Foreig Country) 1S	
show d at	-	10a. State 10b. County 10c. Cit	ty, Town or Lo				10d. Inside City Limit	
28a-f otifie	Director		ilver	Spring	1.0	O''	1 ☐ Yes 2 🕱 N	
a or		10e. Street and Number  505 Marshall Manor Dr.		10f. Zip Code 20905-	10g.	Citizen of What C	ĺ	
r z nous area oean min ne maryano "natural", or items 23a or 28a-f show edical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U Armed Forces?  1 □ Yes 2 ☑ No if Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerk	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	erican Indian,	
than "	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+) 4	(Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired)  Yer for US Army	16l	o. Kind of Business Civilian	s/Industry Emplyoee	
tal Hyg d othe event,	o Be C	17. Father's Name (First, Middle, Last)  Robert Mac Belcher	•	18. Mother's Nam	e (First, Middle, Mai	den Surname)		
th and 7 is m		19a. Informant's Name/Relationship (Type. Print)  Jesse M. Davis/Son	1	ng Address (Street and Number or Ru 5 Marshall Manor I				
nent of ant: If it Iry or o		I Dunai 2 ps Cientation 3 Dhemoval nom State		osition (Name of matory or other place) eake Crematory Inc	Mar 8	E. Location - City o	r Town, State	
Department Important: I any Injury o		21. Signature of Funeral Service Licensee Moo 38	32 22	2. Name and Address of Facility Rapp Funeral & Cre 933 Gist Ave. Sil	mation Server		1 20910-	
hysician /Medical xaminer		23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence)	RDiap	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death	
k	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)  A Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	quence of):				DAYS	
een signed by the attending physician and hould be detached for use as the burial-transit	lical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last  C		un Resistant S	toph A	ureus	JA 41 Wed	
y the attending physic ched for use as the b	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 D No 9 ☐ Unknown  23c. If yes, outcome pf pregnat 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of co	aldeath 3	]Ectopic pregnancy ] Other (specify)		23d. Date of de Month	elivery Day Year	
been signed by the s should be detached	by	Part II. Other significant conditions contributing to death but not res  Aspuration Previous	-tu			42.5	to the cause of death? Probably 4 □Unknov	
has je 2	Completed	Malartritcon			24a. Was an autopsy performed 1∐ Yes 2	prior to death?		
certificate ector, paç	Be	25. Was case referred to medical examiner?  Hospital:		Othor	th (Check only one)			
h. After th funeral	tion: To	27. Manner of D th 1 Natural 5 Pending (Month, Day Year)	ER/Outpatier 28b. Time o Injury		Nursing Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred			
after death.  Director: After I in by the fune	ertification;	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At he building, etc. (Specification of the second of	l ome, farm, str fy)		28f. Location (Stree City or Town, S		Rural Route Number,	

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detailed.

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D52865 29d. Date signed (Month, Day, Year) 2008

30. Name and address of person who completed clause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) MAR 14 2008

32. Pojistrar's Signature

State Registrar

Certification: To

Medical

the Hospital or Attending Physician: The law requires that

			For State	State of Ma	_	-				lental Hy	giene	2000	00001
			Registrar	f (1)		Cei	rtificate o	t Deat	tn		Reg. No.	2000	00301
26	Physicia	an	1. Decedent's Name (First, Middle,	•						2. Date of Dea Month	Day	Year	3. Time of Death
44	/Medic		Louise H. Dor							March			10:45 P M
	Examin	er	4a. Facility Name (If not institution, g				4b. City, Towr		on of Death			County of Death	
	-ng n 2 168 ma	-	Maplewood Park  5. Social Security Number 6		a (In um lant hirt	holand	Bethe		der 24 Hrs.	O Data of Bid		ontgome	
L	Funeral		·	1 M 2 N F	ge (In yrs. last birt 90	riuay) Yrs.	Months Day			8. Date of Birt (Month, Day	v, Year)	Cou	place (State or Foreign intry)
	Director		043-40-8146 Usual Residence of Decedent		90					March 8,	1910	New	York
	land ow it		10a. State 10b. County		10c. City, Town	or Lo	cation						10d. Inside City Limits
	Mary f sh	jo	Maryland Montgo	omarv	Bethes	da							1 ☐Yes 2X No
	the 28a notif	Director	10e. Street and Number	листу	Deches	ua	10f. Zip Cod	e		T	10g. Citize	en of What Cou	intry?
	aa or		9707 Old George	town Road			208	14			Unit	ted Sta	tas
	ns 2: ms 2: mus	era	11. Marital Status	12. Was Decedent		13.			Origin? (Spe	ecify Yes or No- Rican, etc.)		4. Race - Ameri	
·~	fter o	Funeral I	1 ☐ Never Married 2 ☐ Married	Armed Forces?  1 X Yes 2 ☐ If Yes, Give		1				Rican, etc.)		Black, White	, etc.
21215-0036	urs a al'', o Exa <u>n</u>	þ	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	WWII		1⊡Yes 2∭XIN	lo Speci	cify:		5	Specify: W]	hite
9	72 ho natur ical	Completed	15. Decedent's (Specify only highest	Education	16a.	Dece	ient's Usual Oc	cupation	nact of work	ina	16b. Kind	d of Business/Ir	ndustry
2	thin 7	ple	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life.	kind of work do OO NOT use ret	rired)	nost of work	ng			
7	d wit gien er th	Š		4		Νυ	rse					Nursing	g
g	al Hy I oth	Be (	17. Father's Name (First, Middle, La	ist)				18. Mo	other's Name	(First, Middle,	Maiden S	Surname)	
<u>a</u>	should be filed within 72 hours after death with the Maryland and Mental lygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	일	William Castle	Herrick				Ma	ırjori	e Water	man		
Maryland	2 sho and is ma		19a. Informant's Name/Relationship	(Type. Print)	19b.	Mailir	ng Address (Stre	et and Nur	mber or Rura	al Route Numbe	er, City or	Town, State, Zi	p Code)
	and and not not not not not not not not not not		Robert Frederick	Donhauser					ane, N	orth Be	thesc	la, MD	20854
Se	es 1 of He fiten		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	20b. Place of cemeter	Dispo y, crei	sition (Name of natory or other)	olace)	May	ate	20c. Loc	ation - City or T	own, State
Ĕ	Pages nent of I ant: If ite ury or o		4 □ Donation 5 □ Other (Spe		Center	c C	emetery		200		Norfo	lk, Conn	ecticut
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lic	ensee		P.0	Name and Ad	dress of Fa	acility	rol Homo	Roth	oodo-Cha	vy Chase, Inc
m	e a m e		William a.	temphes	M01173	75	57 Wiscon	nsin Av	venue.	Bethesda,	Mary	land 208	vy Chase, Inc 314
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused	d the death. Do n	ot ent	er the mode of	dying, such	as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		ratory F							1	Onset and Death
	/Medical		resulting in death)	u	a consequence of		urc						
ľ	Examiner			Pneumo	onia								
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of	of):							
	cutec nd ransi	Examiner	if any, leading to immediate cause. Enter Uncertainty Cause (Disease or injury that initiated events	c. End St	tage Dem	ent	ia						
Ó	exe an ar rrial-t		resulting in death) Last	Due to (or as	a consequence of	of):							
8760	ficate be executed physician and s the burial-transit	dical		d				_					
9	rtifica ng ph as th	/led	IE EEMALE.										
. Box	th ce rendir	an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐Live birth	pf pregnancy 2  Fetal death	3.	Ectopic pregna	ncv			23	Bd. Date of deliv	,
E	dea death	sick	in the past 12 months? 1 ☐ Yes 2 ☒ No	4□Pregnant a 9□Unknown			Other (specify			· · · · · · · · · · · · · · · · · · ·		Month	Day Year
л О	at the by the	چ	9 ☐ Unknown							_			
- Ś	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Me	Part II. Other significant condition	s contributing to death b	ut not resulting in	the u	nderlying cause	given in Pa	art I.				the cause of death?
Vital Records,	w require been signature	ed	-							1 🗆 Y	′es 2. 🖸	No 3∏Pro	bably 4 □Unknown
ပ္က	aw rass be	Completed								24a. Was autop		24b. Were aut	opsy findings available ompletion of cause of
ř	The tre has age	E								perfor	rmed?	death?	
<u> </u>		BeC	25. Was case referred to medical					26. Pla	ace of Death	(Check only o			2010
	ysic is ce direc	0	examiner? 1  Yes 2  No	Hospital: 1 ☐ Inpatie	ent 2 ER/Out	patier	t 3 DOA	Other: 4 🛭	Nursing Ho	me 5 Resid	lence 6	□Other (Spec	ifv)
0	g Phys ter this neral di	n: T	27. Manner of Death	28a. Date of Inju (Month, Da		ime o	28c. lr	njury at Vork?		28d. Describe h			
<u>ō</u>	ath. r: Afrie fur	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigat		y roary ii	ıju. y		☐ Yes 2	!□No				
DIVISION or	Atte	Certification:	3 ☐ Suicide 6 ☐ Could not determine	ad   28e. Place of Inj	ury - At home, far c. (Specify)	m, str	eet, factory, office	ce		28f. Location (S City or Ton	Street and	Number or Rui	al Route Number,
5	tal or s afte al Dii	Se l		banang, o.	or (opcomy)				- 1	Only or You	m, olale,		
	ospit hour unera ly fille		29a. Certifier 1 🔀 Certifying (Check only 2 Medical Ex	Physician: To the best	of my knowledge	, deat	occurred at the	e time, date	and place,	and due to the	cause(s) a	and manner as	stated.
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, I	Medical	one)	caminer: On the basis o and manner st		a/UT IN	vesugation, in n	iy opinion, (	ueain occur	ed at the time,	uate and p	piace, and due	to the cause(s)
	To t To t	Ź	29b. Signature and title of certifier				29c. Lice	ense numbe	er		29d. Date	signed (Month	, Day, Year)
1	. \		Moster	n Vem	wy 1	ru	D35	791			Marc	h 13, 2	2008
1	ntl		30. Name and address of person wh	, - , - , , -	- /	-	Print)						
	1		Merlyn K. Vemur			ia	Avenue	#227,	Silv	er Spri	ng, M	laryland	1 20902
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature								
	Registr	2 P		EF	1. 4	0.40							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** March 7, 17:50 2008 Verna J. Dawn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Director Jan. 28, 1922 North Dakota 476-16-1232 Usual Residence of Decedent death with the Maryland 10a, State 10h. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 11∏Yes 2 No Director Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Baltimore Road 20852 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify. 3 ☐ Widowed 4 X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Lahti Henry Ida J. Jamsa ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is 13400 Lydia Street, Silver Spring, Maryland 20906 Janice Melia / Daughter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 17. 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cemetery Silver Spring, Maryland Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Ave., Rockville, MD 20850 21. Signature of Funeral Service Licenses any ir M01193 23a. Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Cerebrovascular Accident attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No 24a, Was an autopsy performed? Yes 2 No Division or Vital 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 

Inpatient 2 □ ER/Outpatient 3 □ DOA 1 ☐ Yes 2 ☑ No this 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? (Month, Day Year) 1 X Natural Injury 5 Pending investigation Hospital or Attendi 24 hours after death. Funeral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License numbe Culemul MD DOOGS819 03/08/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDICAL 9901 CENTRA DRIVE ROCKVILLE, MA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar amend #7&8 Per FH G880 6/24/098tifUtate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** P.M. David Travis Drehoff March 16 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Himare Yashinaten Nodical Center Gkn Durnie Hrne Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Ye Dec. 12, Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Year 1966 1**X** M 2□ F <del>40</del> 41 216-88-3272 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If them 23a or 28a-f show limportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madreal Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 75 Milburn Circle 21122 USA Drehat Devid 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Driver Fedex 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Drehoff, Jr. Jean Ellen Daughtry James 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Paul A. Drehoff (Brother) 315 Hampton Rd., Linthicum, MD. 21090 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Baltiffiore Crematory of other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 3/12/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) @ Loudon Park 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Live 3620 Wilkens Ave., Baltimore, MD 21229 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) astroin 785 3 /RY 2 Physician /Medical Due to (or as a consequence of) **Examiner** IRR HOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed attending physician and for use as the burial-transit 0 Due to (or as a consequence of): P.O. Box 68760, Physician/Medical death certificate IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 ☐ Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy performed? certificate 1 Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Minpatient 2 ER/Outpatient 3 DOA 2 funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After (Month, Day Year) Injury 1° Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide determined ts Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR 14 2008



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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12, CLARA M. DAMMANN MARCH 2008 3:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death OAKCREST CARE CENTER PARKVILLE Baltimore 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 X F Director 214-16-9274 89 17,1918 MD Usual Residence of Decedent within 72 hours after death with the Marylanc 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1804 Forrest Rd 21234 Funeral USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 **∑**No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 HOME MAKER OWN HOME marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental ss 1 and 2 should by Health and Menta GEORGE ZIEGLER CLARA MASKEL ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN DAMMANN-HART/DAUGHTER BATLIMORE, MD 21234 1804 FORREST RD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ō permit. Pages
Department of
Important: If It
any Injury or o 1 XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/14/08 PARKWOOD CEMETERY BALTIMORE, MD 21. Signature of Funeral Service Lig 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC. 6415 BELAIR RD BALTIMORE, MD 21206 w 23a. Part1. Enter the disease, or n shock, or heart fall re. . . . . t only Implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Find disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 1 ☐ Yes 2 ☐ No 2 No furieral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred A er Certification: 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident to: 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ublither Blud Etosha 8800 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 Registrar

DHMH 17 Rev 1/2001

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Box 68760.

P.O.

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Division

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Funeral Director		5. Social Security Number 217-35-9639 6. Sex 1 № 2□ F 7. Age 1	(In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 07/25/	1930 9. Birth Con	nplace (State or Foreign untry) UKRAINE		
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P.O. Box 68760. Division or Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** mes /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death **Examiner** inden Avenue 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1**X**M 2□ F Yrs. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at 1 7es 2 No items 23a or 28a-f sh ner must be notified MI Director 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Iral", or item Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 3 Widowed 4 Divorced ✓Yes 2 No 1 ☐ Yes 2 No I Yes, Give Year or Dates: "natural" er than "natur, the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chemical Maryland Be 2 Informant's Name/Relationship (Type. Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balb.MD Baltimore, Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final metastati **Physician** Cance Colon disease or condition resulting in death) /Medical Due to (or as a consequence of) PULS Examiner Sequentially list conditions, if any, leading to him districtions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami Due to (or as a consequence of) physician Completed by Physician/Medical attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) ed by the a detached f Yes 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2□No To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner?
1 ☐ Yes 255 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28h. Time of Medical Certification: 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

I Director: / 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide within 24 hours aft

To the Funeral D

completely filled in 1 Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Brook completed cause of death (Item 23a) (Type, Print) 30. Name and address of person will Rodney Sok 3120 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 4 2008 Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

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5.47 AM

9. Birthplace (State or Foreign

10d. inside City Limits

Approximate Interval Between Onset and Death

Few DAYS

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2008

Physician /Medical Examiner

1 - State Registrar

MARGARET

FAULKNER 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOWARD HOWARD COUNTY GENERAL HOSPITAL COLUMBIA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day, Year) 8/05/1946 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 🕶 F 61 Director 214-50-8382 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location ns 23a or 28a-f show must be notified at HOWARD LAUREL MD Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20723 USA 28 MIDWAY AVENUE Funeral iral", or items ? Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL MEDICAL PACKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be WILLIE FAULKNER ETTA NEWTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9937 NALOR AVENUE, LAUREL, MD 20723 19a. Informant's Name/Relationship (Type. Print) CLARINE MOORE / SISTER Department of Health Important: If Item 27 any injury or other to 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State FIRST BAPTY O'CHURCH CEMETERY 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/22/08 GUILFORD, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21. Signature of Faheral Service Licensee 10220 GUILFORD ROAD, JESSUP, MD 20794 ase, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on eech line. ther the divides , or heart foure. Immedia e ause (Final disease or condition resulting in death) HEART FAILURE CONGESTIVE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, It any leading to infinite data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): 68760, Physician/Medical IF FEMALE: Records, P.O. Box 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PLEURAL COLITIS. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 page Division or Vital 1□ Yes 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 10X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD 10062634 03/12/2008 30. Name and address of person who completed cause of death (item 23a) (Type, Print) COLUMBIA 10802 HICKORY RIDGERD MATEEN AWAN

State Registrar

31. Date filed (Month, Day, Year)

MAR 14

2008

LAVIKA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician FAUL 1109 AM March 12 /Medical 2008 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bayview Medical Center Baltimore Johns Hapkins If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X**)M 2∏ F Director 219-38-1081 23,1941 66 June Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examlner must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Co. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 833 South 50th Street 21222-1228 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White ģ 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A Computer Programmer <u>Esskay Meats</u> marked other injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If item 27 Is marked or Peter Michael Fryza Catherine M. Wisniewski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy M. Fryza - Wife 833 South 50th Street Baltimore, MD 21222 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Mary Cem. 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, MD 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service License any 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 2 days Meumonia /Medical resulting in death) Due to (or as a consequence of): Examiner Glioblustina multiforme year Sequentially list conditions, if any hadren to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine and I-transit certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year ned by the a 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Embousm should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 autopsy perform certificate 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ဂ္ 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: Hospital or Attending 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ٥ 2 2008 RES -000 March 12 Mesti cal Doctor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar MD, 600 North Worke

Registrar's Signature

Street

Baltimore

G Muthappan

Palantappan

31. Date filed (Month, Day, Year)

Maryland 21287

08-01963

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Antoinette Fisher		St.	ate of	f Maryla	nd / D	eparti	ment of <i>licate of</i>	Health	and	Menta	ıl Hygi		eg. No.	20	08 083
	Da	gistrar Decedent's Name (First, Middl	e Last)			Certii	icate of	Deam				Date of Dea	th	V	3. Time of Death
Pnysician Mal Examine		Antoinette I		Fish	2020						N	Month Narch 10			0845 hrs
1		a. Facility Name (if not institution	n, give s	treet and nu	mber)		4	b. City, To		ocation of I	Death		4c.	County of Deat	h
		726 S. Ellwood Avenu	e					Baltim			- · · · · · · · · · · ·	Data (D)	45 (1 41 47	N/A	rthplace (State or Foreig
Funeral	5	Social Security Number	6. Sex		7. Age (In	yrs. last	birthday)	If Under		If Under	Min.			Co	ountry)
Director	2	218-48-4754	1 N	1 2 XF		60	Yrs					Oct. 1	6,19	147 M	lary Land
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fand -f sho	إ	Mary Land N,	/ A 			Bair	imore	10f. Zip	Code				10g. Citi	zen of What Co	untry?
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with the Maryland ms 23a or 28a-f show be notified at once.		726 S. Ellwoo	od A	12. Was Dec	cedent Eve	er in U.S.	13. Wa	is Deceder	nt of Hisp	anic Origin	n? (Spec	ify Yes or N		14. Race - Ame	erican Indian, Black,
ath wittems	Funeral	Never Married 2 N	arried	Armed F			lf Y	es, specify	Cuban,	Mexican,	Puerto Ri	can, etc.)	1	White, etc.	ite
rer de		3 Widowed 4 VDi	vorced 1	f Yes, Give Yea or Dates:			1	Yes 2						Specify:	
urs af	핡	15. Decedent's Education (Sp.				eted) 1	16a. Deceder	nt's Usual ( nost of worl	Occupation	on (Give ki	ind of wor use retired	rk done d)	16b.	Kind of Business	s/Industry
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15-0 Sled v Hygi d oth		7. Father's Name (First, Middle												owski	
	e l	Charles Andr	ルミスK ship (Tv	<u> </u>	2		19b. Mailin	g Address	(Stree	t and Num	ber or Ru	ral Route N	umber, (	City or Town, Sta	ate, Zip Code)
MD 2 nd 2 shou alth and M m 27 is n aumatic	Mrs. Karen Bowser-Daughter  20a. Method of Disposition  1010 Walters Mill Road Forest Hill.  20b. Place of Disposition (Name of cemetery, Date 20c. Location - Ci								Hill. M	ID 21050					
and 2 and 2 fealth item 2 trau	20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State  4  Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  Holu Rosaru Cemetern 3/15/08 Baltimon								or Town, State						
Baltimore, pernit. Pages I an Department of Hee Important: If ite		1 Burial 2 Cremation		Removal	from State	HO	721 ROG	e man	Como	+omi	3/1	5/08	E	Baltimor	re, Maryland
Itin	H	4 Donation 5 Other 21. Signature of Funeral Service	e Licens	ee		110	22	Name and	Address	of Fac ity	922	Wise	Aver	ue Duna	dalk,MD 2122
Ba Perm Depi	21. Signature of Funeral Service Licensee  22. Name and Address of Fac ity 922 Wise Avenue Dundalk, 1  23a. Part I. Enter the disease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart											Approximate Interv			
Physician	failure. List only one cause on each line.											TOCK, OF HEAR	Between Onset ar		
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aminer		or condition resulting in death)	Ī	Due to (or as	a consequ	uence of)	):								
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be executed sician and curial - transit	dical	UNPENDED		AMENDE	)										
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Box 6876C e death certificate the attending physe	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the	1 Live	e birth		2 🔲 I	Fetal death	3	Ectopi	c pregnar	ncy	1	Month	Day Year
X 6 th cert	icia		Jnknown		gnant at ti	me of de	ath 5	Other (Sp.	ecify)						
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, P.O. ires that the signed by I be detach	þ	Part II. Other significant con	4,1,0,10	00.11.120.11.5	,		·				_	1	Yes 2	No 3 ✔	Probably 4 Unknow
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tal ician: certif	Be	25. Was case referred to med examiner?		Hospital:	Inpatier	nt 2	ER/Outpatie	ent 3	DOA	Other <sub>4</sub>		ng Home 5	Res	sidence 6	Other: Scene
Division of Vital Records, rad or Attending Physician: The law require rafter death.  al Director: After this certificate has been silted in by the funeral director, page 2 should be	To	1 Yes 2 No 27. Manner of Death	_	28a. Da	ate of Injur	у	28b. Time		28c. Inj	ury at Wo	rk?	28d. Desci	ibe how	injury occurred	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after feath. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transi		20a Cortifier	Physic	ian: To the	best of my	knowled	dge, death oc	curred at t	he time,	date and p	olace, and	due to the	cause(s	) and manner as	s stated. to the cause(s)
To the within 2 to the complet	ledical	one) 2 Medical!		er:On the bas and manne	sis of exan er stated.	nination a	and/or invest					a, the ulle,	20	9d. Date signed	(Month, Day, Year)
FSFS	Me	29b. Signature and title of ce	rtifier		0			12		nse numbe C.M.E.	21			March 10, 20	
		Joen	Je	y w					<u> </u>	J.IVI.⊑.					
7	30. Name and address of person who combleted cause of death (Item 23a)  Tacha Greenberg MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201														
		Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201													
S		31. Date filed (Month, Day, Yo	1 201	na 🎉	Per ale	o Signa		SAR!							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician WILLIAM R. GRAHAM 7:40P M MARCH 8 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** TIMONIUM BALTIMORE STELLA MARIS HOSPICE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 4/07/1957 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F MARYLAND 214-68-2622 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at N/A BALTIMORE CITY 1 X Yes 2 No MD Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 4312 SEMINOLE AVENUE 21229 USA Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Armed Forces?

1 Yes 2 No AIR

If Yes, Give
Year or Dates: FORCE 1 ☐ Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER TRANSPORTATION permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important: If item 27 is marked other 1 any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM A. GRAHAM CAROL HARVEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARLENE GRAHAM / WIFE 4312 SEMINOLE AVENUE, BALTIMORE, MD 21229 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Nation 3 □ Removal from State 3/15/08 KING MEMORIAL PARK WINDSOR MILL, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of uneral Service Licensee 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD white the disease, or complications that caused the death. not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Pay Immediate ause (Final disease r condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Co Sequentially not our differe, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be exec Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) the 8 9 I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autops, performed? 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 X No 1 | Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 24 hours after death Puneral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records,

Maryland 21215-0036

29a. Certifier (Check only one)

and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (Eirst, Middle, Last) 2. Date of Death Month Year **Physician** 2008 March /Medical Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Ha autimore -141119 1 Year If Under 24 Hrs. Security Numbe Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 18. Year) Months Days Min. 3704 1 M 2□ F Hours Director April 26 Mary Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1 Yes 2 □ No MIS Director BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ıral", or items 23a or Examiner must be ı 2/206 Hamil ton 4105 Hvenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: White 3 Widowed 4 Divorced Completed Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRE CISION 60 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ᅙ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) arie emmon-20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Method of Disposition Burial 2 ☐ Cremation 3 Removal from State Donation 5 Other (Specify) DALTIMORE ML 21. Signature of Funeral Service Licensee BALTIMORE Evans Funeral Chapolul rema 23a Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart falture. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** VABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) neral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certification: To Be Completed by 4 Donknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a Was an autopsy 1∐ Yes a No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 | Nursing Home 5 | Residence 6 Mother (Specify) ASSISTED LIVING 2[[] No 1 TYes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

Date filed (Month, Day,

MAR 14

Year!

2008

cause of death (Item 23a) (Type, Print)

€32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician**  $P^{M}$ Yolanda Georganas March 2008 5:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🕅 Hours Min. Director 579-44-8579 94 Oct. 27, 1913 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at fshow 1XIYes 2 □ No Director |Maryland| Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or items 23a or Examiner must be r United States 301 Russell Avenue 20877 filed within 72 hours after death Hygiene. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🋣 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married Specify: White or than "natural", or the Medical Exami 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify 2 3 X Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Restauranteur Restaurant permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, il 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Antonino Chiantella Maria Brocato ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Athanasia Georganas-Ponsart/Dtr. 5913 Massachusetts Avenue, Bethesda, Maryland 20816 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State March 14, 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Silver Spring, Maryland Gate of Heaven Cemetery 21. Synature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. DOWZ M01193 300 W. Montgomery Ave., Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Coumonth /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine executed burial-transit and Due to (or as a consequence of): attending physician for use as the burial Box 68760 be Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. signed by the a 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part Is 23e. Did tobacco use contribute to the cause of death? Records, ģ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s Demuile this certificate 2 No Division or Vital Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident the 1 Director: 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 0 within 24 hours a To the Funeral Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

LY. ROBERT 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



DHMH 17 Rev 1/2001

ass

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20/2UJSELL AVENUE

29c. License number

004115

29d. Date signed (Month, Day, Year)

CAITHERS BURG, NUS 20877

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of rtificate of		l Mental Hy	giene Reg. No.	2008	08314
	Physic		1. Decedent's Name (First, Middle, La Joem Davis		neu			2. Date of De Month	ath Day	Year . 7,008	3. Time of Death 0 5 4 0 M
	/Medi Examii		4a. Facility Name (If not institution, give Brooke Grove Rebas)  5. Social Security Number 6. S	street and number)		4b. City, Town, Sandu If Under 1 Yea	or Location of De	ath	4c.	County of Death	ery
	Funeral Director		213-40-8303 Usual Residence of Decedent	M 2 Ø F 7. A9	96 Yrs.	Months Days			y, Year) 25, 19	Cor	place (State or Foreign intry) Carolina
	the Maryla 28a-f shov	rector	10a. State 10b. County  Florida Collier  10e. Street and Number		Naples	10f. Zip Code			10a Citi:	zen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 🕅 No
920	be filed within 72 hours after death with the Maryland stal Hygiene.  Id other than "natural", or iteme 23s or 28s-f show event, the Medical Exam are must be notified at	by Funeral Director	4501 Gulf Shore B  11. Marital Status  1 Never Married 2 Married 3 XWidowed 4 Divorced	1vd. North  12. Was Decedent I Armed Forces?  1   Yes 2   X   If Yes, Give Year or Dates:	Ever in U.S. 13.	3410	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	Un:	ited St.  14. Race - Amer Black, White	ates
21215-0036	within 72 ho ene. than "natur he Medical I	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5	+) (Give	DO NOT use retir	during most of w	vorking		nd of Business/I	
7	be filed tal Hygi of other	To Be Co	12 17. Father's Name (First, Middle, Last) Arthur W. Davis		Home	maker		ame (First, Middle,		Wn Home Sumame)	
a,	is 1 and 2 is 1 Health ar item 27 is other trau		James Michael Gaf  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □	fney / Son	20b. Place of Dispo cemetery, crei Gate of H	Gulf Sho esition (Name of matory or other place eaven	ore Blvd.	ch 14,	20c. Loc	, Naples	, F1. 34103 Town, State
Baltin	permit. Page Depentment of Important: if any injury or once		4 Donation 5 Other (Specify 21. Synature of Puneral Syrvice Licen	S00	M01193 R6	O W. Mor	ess of Facility Pumphrey ntgomery	Ave. Ro	Home ckvi	ver Spri e/Rockv: lle, MD	ille, Inc.
	Physician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. aspira	ιθ.	er the mode of dy		ac or respiratory a	rest,		Approximate Interval Between Onset and Death
	cate be executed XX physicien and multiple burial-transit en	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. dus on Meto (rase Alzha		isease					years
	death certifi e attending   ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of the control	2 ☐ Fetal death 3 ☐	Ectopic pregnand Other (specify)	oy .		2:	3d. Date of deliv	very Day Year
	sign I be	by	Part II. Other significant conditions co	ontributing to death bu	it not resulting in the u	nderlying cause g	ven in Part I.	23e. Did to		/	the cause of death?
Rec	The law ate has t page 2 s	Completed						24a. Was autop perio 1 🗆 Yes		24b. Were autroprior to condeath?	opsy findings available ompletion of cause of
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🔊 No	Hospital: 1 ☐ Inpatier	nt 2□ER/Outpatien	t 3 DOA O		eath Check only of Home 5 Resid		Other (Spec	(4.)
sion o	Mitter 19	Certification; 7	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day	y 28b. Time of	28c. Inju		28d. Describe h			''
<u>Σ</u>	pital or Attendurs after death are! Director: /		3 Suicide 6 Could not be determined	building, etc				City or Tov	m, State)		al Route Number,
:	vithin 24 hours a within 24 hours a To the Funerel C completely filled	edicai	29a. Certifier SC Certifying Phyone) Check only one)	iner: On the best of and manner state	f my knowledge, death examination and/or invited.	occurred at the trestigation, in my	ime, date and plac opinion, death occ	ce, and due to the curred at the time,	cause(s) a date and p	and manner as place, and due t	stated. to the cause(s)
)	vithin 2 To the complet	Σ	29b. Signature and title of certifier	ATTENDIN	G-PHYSICIA:	29c. Licen				signed (Month,	
j	2		30. Name and address of person who carau Brooke Hoffm	ompleted cause of de	eath (Item 23a) (Type, Slade Scho	Print)	Sante	Spring	Ma	ryland	20860
	Sta Registr	te	31. Date filed (Mpret), Day, Year 008	32. Registra	r's Signature	W				L.	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Helen Louise Gillespie March 9, 2008 9:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hart Heritage Home Street Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F 384-16-7079 Director 87 May 18, 1920 Michigan Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notifled at 1 ☐ Yes 2 X No Directo Maryland | Harford Abingdon 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2908 Airdrie Avenue Funeral 21009 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. δ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Andrew (nmn) Lewandowski Sarah (nmn) Gwizdala 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John A. Gillespie / Son 7639 Lockmont Circle, Anaheim, CA 92808 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. 3-31-08 Arlington, Virginia 21 Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 Part . Ent., the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** VASCULAN LILBIAL 24/4 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed sician and burial-transit Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò FIBRILLADION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform page, 1∐ Yes 2 No 25. Was case referred to medical Be ဥ Certification:

Division or Vital Records, P.O. Box 68760,

funeral director,

within 24 hours a To the Funeral Completely filled

examiner?					. Flace of Dea	an (Check only one)	,	1.0 0/11/
1 Yes 2 ₹	No	Hospital: 1 ☐ Inpatient 2 ☐	☐ER/Outpatient 3☐	DOA Other:	4 ☐ Nursing H	lome 5 Residence	6 ☑ Other (Specify)	CAL
27. Manner of Deal 1 ☑ Natural 2 ☐ Accident	5 Pending investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes	2 □No	28d. Describe how inj	ury occurred	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At h building, etc. (Spec		ctory, office		28f. Location (Street a City or Town, Sta	and Number or Rural Re te)	oute Number,
29a. Certifier (Check only one)	1 ☐ Certifying Ph 2 ☐ Medical Exar	nysician: To the best of my kn niner: On the basis of examin and manner stated	owledge, death occur ation and/or investiga	red at the time, of tion, in my opinion	date and place on, death occu	e, and due to the cause( urred at the time, date a	(s) and manner as state and place, and due to th	ed. e cause(s)

29b. Signature and title of certifier

29c. License number 739889

29d. Date signed (Month, Day, Year) March 11, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALFRED

Bel pin MA 21014 SPANUS 615 W. MACPHAIL

State Registrar

Medical

31. Date filed (Month, Day, Year) MAR 14



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 23a per day 877 03/14/08dhb.
State of Maryland Department of Health and Mental Hygiene Amend Item 1 per dr, g8703/19/08 diffe ath Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Sidney Glover **Physician** 18:05 M FEBRUARY 22 2008 1 0 C.Y /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) May 2, 193 Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours 1**∑**M 2□F 1934 73 Maryland Director 215-30-0031 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 No MD Baltimore Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ed other than "natural", or items 23a or event, the Medical Examiner must be 21222 USA 8 Patapsco Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □ Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: white Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M 8 disabled none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Glover Lillian Ruth Humphrey 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nathan Glover/brother 8 Patapsco AVenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu of Funeral Service State Anatomy Board 655 W. Baltimore Street m Baltimore. MD 21201 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) WEEK **Physician** RENAL FAILURE /Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia Sequentially list conditions, if any, loading to initiodial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disk to (or the a moneogrance of) Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown þ signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy perform certificate 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 3□ DOA ၉ 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; 

completely filled in by the fi 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-DOD FEBRUARY 22, 2008 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) EASTERN AVENUE, BALTIMORE, MD. 21224 MATIVO M.D 4940 CHRISTINE

State Registrar 31. Date filed (Month, Day, Year)

14

MARKET.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 08317

	For State Certificate of Death	Reg. No.
Physician/	egistrar . Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year March 10, 2008  3. Time of Death 1741 hrs
Examiner	Alonzo Marcus Hughes  4b. City, Town, or 1	
	a. Facility Name (if not institution, give street and number)  4b. City, Town, or I  Johns Hopkins Hospital  Baltimore	N/A
Funeral	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days	Foreign MD
Director	$219-02-6106$ $_{1_{X}M}$ $_{2}$ $_{1}$ $_{2}$ $_{1}$ $_{36}$ $_{1}$ $_{1}$ $_{1}$ $_{1}$ $_{2}$ $_{3}$ $_{2}$ $_{3}$ $_{4}$ $_{2}$ $_{1}$ $_{2}$ $_{3}$ $_{4}$ $_{2}$ $_{2}$ $_{3}$ $_{4}$ $_{2}$ $_{4}$ $_{2}$ $_{4}$ $_$	S Hours MIN. 9/16/71 Country) PID
	Jsual Residence of Decedent  10a State 10b County 10c City, Town or Location	10d. Inside City Limits
ow any	MD   N/A   Baltimore	1 X Yes 2 No
the Maryland or 28a-f sh lifted at once	10e. Street and Number	10g. Citizen of What Country?
he Ma n or 28 liffed a	8016 Briar Hill Place 21221	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene and Mental Hygiene 17 is marked other than "natural", or items 23a or 28a-f show natic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Specify Yes or Non, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  African
9 9 9 1	1 Never Married 2 Mindred 1 Yes 2 X No	
is afte	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupa during most of working life	ation (Give kind of work done 16b. Kind of Business/Industry
0036 within 72 hours giene. her than "natu Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5+) Laborer	Home Improvement
o36	12	18.Mother's Name (First, Middle, Maiden Surname)
filed v filled v filled v filled v filled v	17. Father's Name (First, Middle, Last)	Doborah A Dorsey
2121 ould be fil d Mental I s marked lic event,	15d. Informatics (daties to the control of the cont	eet and Number or Rural Route Number, City or Town, State, Zip Code)
MD 12 sho th and 27 is umati	Wife 8016 Briar  Tiffany 1. Moore Hughes 20b. Place of Disposition (Name of Co.	Hill Place, Balt., MD 21221  emetery, Date   20c. Location - City or Town, State
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filted within 72 hours after permit to Fleath and Mental Hygiene. Importanti. If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner To Re Completed by F	20a. Method of Disposition 20b. Flace of Disposition (rematory or other place)	3/14/08 Balt., MD
Page ment o tant:	4 Donation 5 Other Specify: Mt. Carmel Cen	m   ss of FacilityHari P. Close F. Svs,PA
Balt Permit Depart Impor injury	5126 Be	lair Rd. Balt., MD 21206
ysician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying	g, such as cardiac or respiratory arrest, shock, or heart Approximate Intervention Between Onset and
.vledical	failure. List only one cause on each line.  Immediate Cause (Final disease a. Gunshot Wound of the Neck	Death
Examiner	or condition resulting in death)  Due to (or as a consequence of):	
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
nsit	cause. Enter Underlying Cause (Disease or injury that initiated  Due to (or as a consequence of):	
uted ransit	events resulting in death) Last  d.	
0, e be executed sician and burial - transit	UNPENDED X AMENDED 1 per me g878 4-14-0	8 Vt 23d. Date of delivery
760, Teate be physic the burn	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnancy Month Day Year
Records, P.O. Box 68760  The law requires that the death certificate care has been signed by the attending phy page 2 should be detached for use as the b	past 12 months?  4 Pregnant at time of death 5 Other (Specify)	
BO le deat the at	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	se given in Part I. 23e. Did tobacco use contribute to the cause of death?
P.O. that the med by detach		1 Yes 2 No 3 Probably 4 Unknow
ds, F		24a. Was an autopsy findings avail prior to completion of cause
Records, The law requires ficate has been sig		performed? death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
Re: The ifficate		lace of Death (Check only one)
/ital	examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other4 Nursing Home 5 Residence 6 Other:
Division of Vital Records, P.O. nat or Attending Physician: The law requires that the stafter death.  The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	27 Manner of Death 28a, Date of Injury 28b, Time of Injury 28c.	Injury at Work?  28d. Describe how injury occurred  Subject was shot
trendin feath.	Natural 5 Pending Investigation 2 Accident Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office	ce building etc. 28f. Location (Street and Number or Rural Route Number,
l or A after of in breed in br	3 Suicide 6 Could not be	or Town, State) 1800 East 28th Street, Baltimore, Md.
Division of Vital Inthe Hospital or Attending Physician: hin 24 hours after death.  The Funeral Director: After this certifulately filled in by the funeral director.		e, date and place, and due to the cause(s) and manner as stated.
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician	one) 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion and manner stated.	nion, death occurred at the time, date and place, and does to the state of the visit of the state of the stat
5. V. V. V. V. V. V. V. V. V. V. V. V. V.		cense number 29d. Date signed (Month, Day, real)
_	Promile Neighall Mis	N.C.IVI.E.
X	30. Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 111 Penn St	reet, Baltimore, MD 21201
St	Palliela L. Sootiali, MB 7 resistant	OCME
Regist	e 31. Date filed (Month, Day, Year).  32. Registrar's Signature.	OV:

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

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2008

Woods

327 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-01880 State of Maryland / Department of Health and Mental Hygiene Latasha Emily Harris Certificate of Death 1. For State Reg. No Registrar 3. Time of Death 2. Date of Death . Decedent's Name (First, Middle,Last) Physician/ Month Day March 6, 2008 1800 hrs Medical Examiner Emil 4c. County of Death 4b. City, Town, or Location of Death Baltimore 207 Athol Gate Lane Apt A If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Country) Director Yrs 219-90-1550 М 2 1 5 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No altimore 28a-f show death with the Maryland Director 10g. Citizen of What Country 10e. Street and Number a laay 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11 Marital Status White, etc If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married þ Yes 2 No specify: If Yes, Give Yee Pages 1 and 2 should be filed within 72 hours after near of Health and Mental Hygiene and if I item 27 is marked other than "natural", o and: If item 27 is marked other than "natural", o rother traumatic event, the Medical Examiner. Widowed Divorced ρ 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) **Baltimore**, MD 21215-0036 Father's Name (First, Middle, Last) Be Harold Augustino Chamber 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State 3/13/2008 mportant: Donation 5 Other Specify Voughn C. Greene Fineruiservices 21. Signature of Funeral Service Licenses fimore MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Physician Between Onset and failure. List only one cause on each line Death e Medical a. Gunshot Wounds (2) of Head Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate opuce. Enter Underlying Course (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed pue Physician/Medical burial -UNPENDED AMENDED ned by the attending physician detached for use as the burial 23d. Date of delivery Box 68760. 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown g 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 ✓ No 3 Probably 4 Unknown þ Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an has been autopsy prior to completion of cause of death? performed? Yes ✓ Yes 2 1 1 certificate h 26.Place of Death (Check only one) 25. Was case referred to medica the Hospital or Attending Physician; Be Other4 Nursing Home 5 Residence 6 Other: Scene Hospital: examiner FR/Outpatient 3 Inpatient 2 this 1 V Yes 2 No ٩ 28d. Describe how injury occurred 28c. Injury at Work' 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury After 27. Manner of Death Subject shot Certification: FOUND: Yes 2 V No Natural Director: d in by the f Pending within 24 hours after death. 1750 hrs Mar 6, 2008 Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 207 Athol Gate Lane Apt A, Baltimore, MD 3 Suicide To the Funeral Di determined (Specify) Multi-Family Apt. 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 7, 2008 O.C.M.E. ~ IMD. incel 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD Assistant Medical Examiner

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 31. Date filed (Month Dev Rear

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year MARY PATRICIA 03 008 0021 AM HOLCOMB 3 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Baltimore Rosecla Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F Director 215-28-9940 78 Dec. 25,1929 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits Baltimore Director Maryland Baltimore County 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 206 Stevens Rd. 21220 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 4. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married শিত্যিত্ত শিষ্ট্ৰ IVA শ্ৰেম Specify: White 1 ☐ Yes 2 X No Specify. þ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade N/A Housewife Housekeeping~Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Brison Fantom Dorothy Billmeyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl R. Holcomb (Son) 206 Stevens Rd. Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 3-15-2008 Baltimore, Md. 4 Donation 5 Other (Specify) sign to e of Funeral Service Lice se <sup>22</sup>Lassahhdreinfeilal Home 7401 Belair Rd. Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** se PSis /Medical Due to (or as a consequence of): **Examiner** neumonia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an this certificate ha autopsy performed? yes 22 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) 200 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the f 2 Accident 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifie

Binh 31. Date filed (Month, Day, Year)

30. Name and address of person who complete

Na

NOUYOU

death (Item 23a) (Type, Print)

cause of

29c. License number

DO06509L

9000 Franklin Square Drive, Baltimore, MD 3/237

29d. Date signed (Month, Day, Year)

3/13/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 1 per md 9877 3-14-08 yt and Mental Hygiene 008

	For	State of Maryland / Department of Health a
-	State Registrar	Certificate of Death

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,	F	Ph /I Ex un ire		
ox 68760, X Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Marts Haviane	WC		0000
外	Phy /M Exa	8	ransit	a
ox 68760,	n certificate be exe	inding physician and	use as the burial-t	

			Registrar	Certificate of Death	Reg.	No.	0004
			1. Decedent's Name (First, Middle, Last) Edward George	Hammen Sr.	Date of Death     Month	Day Year	3. Time of Death
3.	Physici /Modia		FOWARD HAMMEN		MARCH	Day Year 2008	0748 A M
	/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death	
	_Admin		UNIVERSITY OF MARYLAND MEDICAL CO	ENTER BALTIMORI	ب		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthr	place (State or Foreign
5.	Director		212-48-9906 <sup>1</sup> ™ <sup>2□</sup> F 60	Yrs. Months Days Hours Min.	(Month, Day, Ye July 13,		aryland
			Usual Residence of Decedent		bury 15,	IJ4/ IL	путана
	land Dw			vn or Location		1	0d. Inside City Limits
	Marylan f show ied at	ō	Margland Harford	Tonna			1 □Yes 2 XNo
	the 28a-	9	Maryland Harford  10e. Street and Number	Joppa 10f. Zip Code	10g.	Citizen of What Cour	ntrv?
	with a or	ä		21085	l		,
	s 23	era	544 Riviera Drive  11 Marital Status 12. Was Decedent Ever in U.S.		nosify Vac or No	USA 14. Race - Americ	an Indian
	er de item	Completed by Funeral Director	Armed Forces?	13. Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White,	
36	or i	Y	1 ☐ Never Married 2 ☒ Married 1 ☒ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify:	
00	ural' ural'	D D		Davidson Hand Constitution	1 400	Whi	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	ete	15. Decedent's Education 16s (Specify only highest grade completed)	<ul> <li>Decedent's Usual Occupation         (Give kind of work done during most of work         life. DO NOT use retired)</li> </ul>	king	o. Kind of Business/Ind	dustry
12	vithin ne. han e Me	臣	Elementary/Secondary (0-12) College (1-4or 5+)				
	filed withi Hygiene. other than ent, the M	ပိ		Owner / Operator		Tile Compai	ny
nd	be fil tal H d ott	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid		
<u>ya</u>	should be and Mental s marked o umatic eve	은	George V. Hammen	Amelia	(unk) Zyg	larski	
Maryland	ds bus			b. Mailing Address (Street and Number or Ru			· ·
	and salth 127 er tr		Norma J. Hammen / Wife	544 Riviera Drive, Jo	oppa, Mary	land 21085	5
re	oth oth		l samet	of Disposition (Name of ery, crematory or other place)	Date 20c	. Location - City or To	own, State
Ĕ	Page ent o nt: If		1 ☑ Burial 2 □ Cremation 3 □ Removal from State United State United State United State United State United State United States	ngton Cemetery 3-1:	3-08 Da	rlington,	Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If Item 27 Is any Injury or other tra		21. Signature of Funeral Service Licensee	22. Name and Address of Facility McComas Funeral Hor	5 00   <u>Ba</u>	TTTING COILY	TELLY LOTTO
ñ	permi Depar Impo any Ir		X M IVA	McComas Funeral Hor 1317 Cokesbury Road	me, P.A.	n Marazlar	21000
	Physician		23a. Part1. Enter the disease, at complications that caused the death. Do shock, or heart failure. List only one cause on each line.				Approximate
							Interval Between Onset and Death
}		1	disease or condition a. CLOSTRIBIUM	DIFFICILE SEPSIS			
	/Medical Examiner		Due to (or as a consequence	e of):			
×			Sequentially list conditions, b.	-0.			
Ya	p #is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	e 01).			
g	ecut and tran	аш	that initiated events resulting in death) Last  C	-0-			
, 0	e exitan surial		resulting in death) Last Due to (or as a consequence	9 01):			
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99	certificate be executed nding physician and use as the burial-transit	n/Medical	IF FEMALE:				
XO			23b. Was decedent pregnant 23c. If yes, outcome pr pregnancy	th 3 □Ectopic pregnancy		23d. Date of delive	-
œ.	death e atter	ici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	5 Other (specify)		Month	Day Year
P.0	The law requires that the death ate has been signed by the atterpage 2 should be detached for a	Physicia	9 ☐ Unknown				
Э, Е	s tha ned e del		Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the	he cause of death?
ğ	quire n sig ald b	Completed by	BILATERL LUNG TRANSPLANT, RE	NAL FAILURE,	1 ☐ Yes	2 No 3 Prob	bably 4 Unknown
00	w require been si should I	lete	CORDNARY ARTERY DISEASE	,	24a. Was an	24h Were auto	onsv findings available
Re	has ge 2	ш	CORONARY ARTERY DISEASE		autopsy	prior to co death?	opsy findings available impletion of cause of
<u></u>					1☑ Yes 2□	No 1 ☐ Yes	2 1 No
or Vital Records,	Physician: The la this certificate had ral director, page 2	Be	25. Was case referred to medical examiner?	Other	th (Check only one)		
70	hysi this o	T <sub>0</sub>	1 Yes 2 No 1 Inpatient 2 ER/O	dipatient 3 DOA 4 Nursing H		e 6 □Other (Specif	fy)
n n	ding Phi h. After thi funeral	on:	1 Natural 5 Pending (Month, Day Year)	Time of Injury at Work?	28d. Describe how i	njury occurred	
O D C Could not be							
27. Manner of Death 1						al Route Number,	
	losp t hou unel		29a. Certifier (Check only)  1 ✓ Certifying Physician: To the best of my knowledge 2 ☐ Medical Examiner: On the basis of examination a	ge, death occurred at the time, date and place	e, and due to the caus	e(s) and manner as s	stated. to the cause(s)
	he h in 24 he F plete	Medical	one) and manner stated.			and place, and due t	210 00000(0)
	To t To t	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month,	
			Manca Vovacui	F19796	0	3/07/08	
	10		30. Name and address of person who completed cause of death (Item 23a)	(Tupo Brint)			
	1		Where Novaci 225. Gree	ene St. Baltimere, Mi	0 21201		

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Registrar

31. Date filed (Month, Day, Year)

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Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Sherry Ann Howard February 16, 2008 12:30 p<sup>M</sup> /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chestnut Street *#*703 Delmar Wicomico If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)

New York 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 😿 10/21/1962 44 084-56-7970 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notifled at Md Wicomico Delmar 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 E. Chestnut Street, Apt 703 21875 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced 'natural" 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A ages 1 and 2 should be filed in of Health and Mental Hygic 1: If item 27 is marked other if yor other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Howard Eileen Warren Pages 1 and 2 should nent of Health and Men ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

800 F. Chestmit St. # 703 Delmar, MD 21875 19a. Informant's Name/Relationship (Type. Print)

Carrie Lynn Peters permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 02/22/2008 Catonsville, MD 4 □ Donation / 5 □ Other (Specify) 22. Name and Address of Facility Gary P. March Funeral Home, P.A. 21. Signature uneral Service License 270 Fredhilton Pass., Baltimore, MD 21229 23a. Part1. Inter the dis shock, or heart failu Immediat ause (Final disease or condition resulting in death) ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Probable Cardiac Arrhythmia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1₩ Yes 2□ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier .0 D45995 3/7/08 a. luis, mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Crick, M.D., 560 Riverside Dr., Salisbury, Md. 21801 31. Date filed (Month, Day, Year) 🙇. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

MAR 1 4 2008

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician MARCH 10 Day 2008 Year WILLIAM M. HOLEWINSKI 8:20 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** STELLA MARIS HOSPICE TOWSON BALTIMORE 8. Date of Birth NOV 1, Year 937 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1**∏** M 2□ F 212-34-9306 70 MD. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experiment must be notified at ty⊡Yes 2□No Director N/A MD. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 7016 EASTERN AVE. 21224 UNITED STATES Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2√2 No Specify: þ Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Flementary/Secondary (0-12) College (1-4or 5+) IRON WORKER LOCAL #16 10 TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Menta is marked WILLIAM J. HOLEWINSKI ANNE N. UNKNOWN ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra once. RICHARD HOLEWINSKI/BROTHER 8569 BAY ROAD, PASADENA, MARYLAND 21122 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Pages 1 1 □ Burial 2 □ Cremation 3 □ Removal from State SACRED HEART OF JESUS 3/13/2008 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signe tule of Fuperal Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or neart failure. List only one cause on each line. Onset and Death Immediate see (Final disease or condition resulting in death) Physician CHRONIC OBSTRUCTIVE PULMONARY DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any loading to remodulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a poinsequence offr Exami burial-tran and Due to (or as a consequence of): Box 68760. attending physician certificate be Physician/Medical the. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Year Day 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by to be a signed by the signed by th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 🗆 No 1 ☐ Yes 2X No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: 1 ☐ Yes 2 X No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 MOther (Specify) HOSPICE 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural
2 Accident Hospital or Attending Within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State MAR 14 2008 Registrar

8:20 р.ш.

2008

WILLIAM HOLEWINSK

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7:00 AMM William Stone Jordan Jr. 2008 March 11, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 90 275.30.1381 Director 09/28/1917 NC Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 No Director Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 9707 Old Georgetown Rd. #2620 20814-United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: WW II þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Medicine Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygle. Important: If Item 27 is marked other than any Injury or other traumatic event, the once. Physician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Stone Jordan Sr. Louise M. Huske 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marion A. Jordan/Daughter 9300 Garden Ct. Potomac, MD 20854-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 KCremation 3 ☐ Removal from State Mar 13 Beltsville, Maryland 4 Donation 5 Other (Specify) 2008 Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00382 Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Ent. If the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner neumenia Aspuation Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (oras a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9∏Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 3 DOA P 2 ☐ ER/Outpatient 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Mannes of Death 28c. Injury at Work? Certification: Injury 1 Natural (Month, Day Year) 5 Pending investigation 1 TYes 2 TNo 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At hon building, etc. (Specify) At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 24 hours a 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D66066 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 OLD GEORGETOWN M.D. DOON WONG ANDREW LEUNG-

DHMH 17 Rev 1/2001

State Registrar

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day 2008 Month **Physician** 3:10 P M March 10, Willard Gene Jennings /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3115 Churchville Road Churchville Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1**X** M 2□ F Director 215-28-5300 77 6, 1930 Maryland Apr. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ns 23a or 28a-f show must be notified at 1 ☐ Yes 2X No Director Maryland Harford Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21028 USA 3115 Churchville Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Błack, White, etc. 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give Year or Dates: ō 1 ☐ Yes 2√2 No þ Specify: 3 Widowed 4 Divorced "naturai" White er than "natur the Medical I Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. U.S. Government 12 Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Emmett Jennings Ada (nmn) Boyles ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3115 Churchville Road, Churchville, MD 21028 Doris Lee Jennings / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If ite any injury or of once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Grdn 3-13-08 Bel Air, Maryland 21. Signature of Luneral Service Licensee McComas Funeral Home, P.A. 23a. Part1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Immediate Cause (Final Physician metastatic AdenocARCINOMA month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine sician and burial-transit Due to (or as a consequence of): Physician/Medical SE IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 1 Natural
2 ☐ Accident 5 ☐ Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 or Attending Physician:

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

physician at the burial attending p signed by the a has r this certificate has After s after death.

ii Director: A

d in by the fo within 24 hours at To the Funeral D completely filled in To the Hospital

3 ☐ Suicide 4 Homicide 1 🜠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

29b. Signature and title of certifier

6 Could not be determined

28f. Location (Street and Number or Rural Route Number, Cify or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

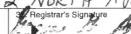
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year) MAR 1 4 2008



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		1	For State Registrar amend #20b I	er FH G87	8 4/10 <i>E</i> Q	tiffeate of L	Death		Reg. No.		3. Time of Death
Dharia			Decedent's Name (First, Middle, Last)					2. Date of De Month	Dav	Year	9:30 P M
Physic /Med			Jamil L. Jerome			4h Oite Town or	Location of Death	March	12, 20	nty of Death	9.30 1
Exami		4.	. Facility Name (If not institution, give st							ltimore	۵
			Stella Maris Hospi	Ce	n yrs. last birthday	Timoni	If Under 24 Hrs.	8. Date of Bir		9. Birthpl	ace (State or Foreign
Funera Directo		- 1	Social Security Number 6. Sex 1X	M 2□ F 39	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Di 09/5/1	968	New	rork
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be filed within 72 hours after death with the Maryland tital Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at			De. Street and Number 103 East Northern	Parkway		10f. Zip Code 21212	2		US		
ath w	3	6		2. Was Decedent Eve	rin IIS 13			pecify Yes or N	o- 14. F	Race - Americ	
er de		1	Marital Status     Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No		. Was Decedent of H If Yes, specify Cuba		o Rican, etc.)		Black, White, 6	
rs afte		ý	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:			ecity: Blac	
do 2 should be filed within 72 hours aft than do Mental Hygiene. ZZ Is marked other than "natural", or traumatic event, the Medical Examptraments.			15 Decedent's Educ	ation	16a. Dec	edent's Usual Occup	oation during most of wor	king	16b. Kind of	f Business/Inc	lustry
nin 72		<u> </u>	(Specify only highest grade	College (1-4or 5+)		e kind of work done DO NOT use retire	d)		Poal	Estate	
filed within 72 Hygiene. other than "nai ent,	۱,	Сошріеле		2	кеа	1 Estate_	18. Mother's Nan	ne (First, Middl			
tal Hy d oth		ne i	7. Father's Name (First, Middle, Last) Dr. Marc Antoine	lerome				Penn Je			
2 should be filed war and Mental Hygie	į,	<u> </u>			19h Ma	iling Address (Street	l	_		wn, State, Zip	Code)
2 sh h and 7 Is rr traurr			19a. Informant's Name/Relationship ( <i>Typ</i> Dr. Marc A. Jerome,		23 S	outhgate,	P.O. Box	x 25537	, St. C	roix U	ISVI 00824
1 and Healt em 2		- 55_	20a. Method of Disposition			454			DO- Loopii	on - City or To	own, State
permit. Pages 1 au Department of Hee Important: If Item any Injury or othe		Ι.	1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Lilltop	position (Name of ematory or other pla Service tion	03/	19/ <del>299</del>	Tows	son, M	)
artme ortan Injur	aù	-	21. Signature of Foneral Service License	e (1)	001 poi a	22. Name and Addr	ess of Facility Ru	ck Tows	on Fune	ral Ho	me, Inc.
permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic ev	Suc		1 Talkala	Budl	0		ork Road			21204	1iata
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the	ne death. Do not	enter the mode of dy	ing, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
Physicia	ın		Immediate Cause (Final disease or condition		EAL CANC	ER					
/Medic			resulting in death)		consequence of):						
Examine		.	Sequentially list conditions.								
/p ==	-	ine.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):						
ecute and trans		Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):						
tificate be exing physician as the burial-											
rtificate be executed ng physician and as the burial-transit		Medical									
certi nding use a			IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome o		3 🗌 Ectopic pregnar	ncv		230	d. Date of deli- Month	very Day Year
death cer attendir ed for use		icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at t		5 ☐ Other (specify)			-		
that the dended by the a		Physician/	9 🗌 Unknown		No at the Ma		ivon in Part I	23e. D	id tobacco use	contribute to	the cause of death?
ss tha gned		by P	Part II. Other significant conditions co	ntributing to death but	not resulting in th	e underlying cause g	given in a arri.				obably 4 🔀 Unknov
he law requires to the has been signed age 2 should be contact.		ted						24a. W		24h Were au	tonsy findings availab
taw reas be		ple						- ai	utopsy erformed?	prior to death?	completion of cause of
The tracted has page		Completed						1 □ Ye	s 2 No	1 ☐ Yes	2 □ No
vitali sician: The scertificate lirector, pag		Be (	25. Was case referred to medical examiner?	Hospital:				eath (Check on Home 5 P		Other (Sne	cify) HOSPIC
Physician: The law requires that the tribic certificate has been signed by the rall director, page 2 should be detached.		ပ္	1 Yes 2X No	1 ☐ Inpatier	nt 2 ER/Outp	atient 3 DOA	4 LI Nurskiy		be how injury of		my Hobris
		ion	27. Manner of Death  1   Natural  5 □ Pending investigation	(Month, Day	( <i>Year</i> ) Inju		fork? □Yes 2□No				
or Attending after death.  Director: After din by the fune	2	icat	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ry - At home, farm	, street, factory, offic	e	28f. Locatio	on (Street and Town, State)	Number or Ru	ural Route Number,
5 # # # E	2	Certification:	4 ☐ Hornicide determined	building, etc	. (Ѕреспу)						
DIVISION  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the			29a. Certifier 1 ★ Certifying Ph	/siclan: To the best of iner: On the basis of	of my knowledge,	death occurred at the	e time, date and pla	ace, and due to	the cause(s) a me, date and p	and manner a place, and due	s stated. to the cause(s)
e Ho 1 24 h e Fur	Jeren	Medical	(Check only 2 Medical Examone)	and manner sta	ted.					signed (Mont	
To th	1	Me	29b. Signature and title of certifier			29c. Lice	ense number		1	7 Los	
				1-1			43721		200	7-01	
1.			30. Name and address of person who				mT1/01/TT	w w 0	1002		
Q			DR. TARIO MAHMOO	D 2300 DI	JLANEY VA	LLEY RD.	TIMONIU	M, MD 2	1093		
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9:30 р.ш.

MARCH 12, 2008

JAMIL JEROME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year ohnson 24 PM /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ON SECOUR 5. Social Security Number Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday, If Under 1 24 Hrs. Min. Birthplace (State or Foreign Country) **Funeral** 1 2 M 2 □ F Days Hours 212-46-028 Director Vlanc Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 □ No Directo Timore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA Funeral -12/6 12. Was Decedent Ever in U.S. Armed Forces? 1 X es 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Z No Specify: þ 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. tem 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Der Visol 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be hnson aam ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra md, 21201 - oren 20 - brother ennsylvania Ave Johnson Balto, 20a. Method of Disposition Date 20c. Location - City or Town, State 1⊠Burial 2 □Cremation 3 □Removal from State 08 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service Licens 22. Name and Address of Facility 270 Fred HILTON Pass Jan P. march Fitt. 23a. Part I nor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Phahdomy 01 **Physician** disease or condition resulting in death) UNLINOUS /Medical Due to (or as a consequence of Examiner taholiz Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ncnown The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No After this certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: P 1 XInpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [ 🕰 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 66335 Mouch 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State
Registrar

GEOFFRE

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Her rank March /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner are timore altimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Min. Days Hours 1XM 2□F 206-01-033 Director Oct 26, 1919 Tennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County show 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director altimore Itimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ▼ Married 5-0036 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) -nginee 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mentai ၉ axton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 i DOUSE Ann Gare Keck Daltimore MD 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Event Funcial Chapelot Cremation Services - Belgin 3 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☑ Cremation 3 Removal from State 2008 4 □ Donation 5 □ Other (Specify) st /till 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services - Parkolle 8800 Harford Road Parkville MD 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequented) Examiner Sequentially list conditions, any, taken to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the death certificate be executed burial-transi and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records. þ 3 ☐ Probably 4 ☑ nknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an page 2 s certificate 2 No 1□ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2[=\No 4 Nursing Home P 1 Inpatient 2 ER/Outpatient 3 DOA 5 🗌 Residence this 6 □Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation 2 □ No 1 Tyes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

within 24 hours after death.

To the Funeral Director: After to completely filled in by the funera To the Hospital Medical 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8800 Etosha wolther 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 DEREGEL Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM/10e 18 19b per FIT C878, 4/3/08 US
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year 13th 2008 12:38 PM March Mary N. King /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Belair Health and Renabilitation Center Bel AIR If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔽 F 216-34-6732 Director Maryland 12-02-1936 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Balmoral Balmozal permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 233 any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, the Medical Examiner must once. by Funeral 21014 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 18. Mother's Name (First, Middle, Maiden Surname)
Piraino 17. Father's Name (First, Middle, Last, Be Charles B. Lazzelle ပ Mary Pirino 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1512 Balmozal Dr Bel Air, MD 21014 Donald King (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 03-14-2008 | Baltimore, Maryland <sup>22. Name and Address of Facility</sup> Schimunek Fuenral Home of Bel Air Inc. 610 W. MacPhail Rd Bel Air, MD 21014 21. Signature of Funeral Service Sicensee Brien D. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ue to (o as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-trar Due to (or as a consequence of) attending physician a for use as the burial Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 4 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an cate has page 2 s autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate i completely filled in by the funeral director, pag 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manuer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print 30. Name and address of person who completed cause 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 4 2008 Registrar

DHMH 17 Rev 1/2001

MARY

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 03-09-2008 Anne Marie Kugler 1858 p 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Upper Chesapeake Hospital Bel Air Harford If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12–31–1938 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Months 1 □ M 2 7 F 69 125-30-2304 New York Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d Inside City Limits 1 ☐ Yes 2X No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1310 Sheridan Place Unit 209 21015 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary Law Firm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Angelo Veltri Stella Bosco 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. Kugler (Husband) 1310 Sheridan Pl Unit 209 Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03-15-2008 | Fallston, Maryland Highview Mem. Gar. 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the dewh. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence/of) 4/2 Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury Due to (or as a misequen that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 ☐ Unknown Part II. Other significant conditions contrib ting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X ER/Outpatient 3 □ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

or Attending 4 hours after death. Funeral Director: ₽ within 24 hours at To the Funeral D

Physician

/Medical

Examiner

Funeral Director

Completed by

**Funeral** 

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Pages 1 ment of H

Important: If It any Injury or o once,

Physician

/Medical

Examiner

death with the Maryland

Physician/Medical þ Completed Be Certification: To

29a. Certifier

(Check only

Medical

State Registrar 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

1 Natural 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

29d. Date signed (Month. Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 04 Plumtr

31. Date filed (Month, Day, Year)

MAR 1

32. Redistrar's Signature

			For State Registrar	State of	of Maryla	and / Depa <i>Cei</i>	artment of F	lealth a	and Me	ental H	ygie Reg	/ 1111	8 08	332
			Decedent's Name (First, Middle	, Last)						2. Date of D		. 110.	3. Time of	f Death
	Physici /Medio			Gertru	ıde Bi	Lackwood	Kelly			March March	9,	2008 Year	7:40	A M
	Examin		4a. Facility Name (If not institution	, give street and nu	mber)		4b. City, Town, o	r Location o	of Death			4c. County of De	ath	
	<u> </u>	- 2	Suburban Hospi				Bethe					Montgom		
	Funeral		5. Social Security Number 200-14-5814	6. Sex 1 ☐ M 2 🛣 F	7. Age ( <i>In y</i>	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under:	Min.	8. Date of E	Birth Day, Y	9. B 1924 Pe	irthplace (State o	or Foreign
	Director		Usual Residence of Decedent		0.5				I^v	March	21,	1924 Pe	nnsylvar	iia
	yland how		10a. State 10b. County		10c.	City, Town or Lo	cation						10d. Inside C	ity Limits
	e Mar ta-f sl	ctor	Maryland Montg	omery		Bethesd	a						1 □Yes	2 No
	or 28	Director	10e. Street and Number				10f. Zip Code				10g	. Citizen of What 0	Country?	
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20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at one.	by Funeral	11. Marital Status 1 □ Never Married 2 → Marri 3 □ Widowed 4 □ Divorced	Armed Formed Formed Tight Armed Formed ve		Was Decedent of H f Yes, specify Cub 1 □ Yes 2ሺ No	lispanic Orig an, Mexicar Specify:		oify Yes or Natican, etc.)	10-	14. Race - An Black, Wh Specify: W	ite, etc.		
222	hour tural	ed b	15. Decedent	Year or D	oates:	16a Decer	dent's Usual Occup	ation			16			
<u>.</u>	in 72 n "na Nedic	Completed	(Specify only highes	t grade completed)	4.4. = 3	(Give	kind of work done OO NOT use retired	during most d)	t of working	g	161	o. Kind of Busines	s/Industry	
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7	ould b Ment arked aric e	2	Oswald H. Black	wood						de P.				
<u>a</u>	2 sho		19a. Informant's Name/Relationsh			I	g Address (Street							
ב נו	1 and Health		William C. Kell  20a. Method of Disposition	y / Husba		9320 D. Place of Dispo	Renshaw				_			
5	ages nt of h		1 ☐ Burial 2 X Cremation		State	cemetery, crer	natory or other plac	ce) ]	March			c. Location - City o		,
altillo	nit. Partme		4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service I		MO		Crematorium	- :	2008			ethesda,		
0	permi Depar Impor any Ir		Magnifette Po	mest		1/5	Name and Addre Dert A. Pun 7 Wisconsi	n Aveni	ue, Bet	thesda,	Ma	ryland 208	y Chase, 14-3501	Inc.
	-0.7		23a. Part1. 5 ter me disease, or shoot for heart failure. List of	complications that only one cause on e	caused the de each line.	eath. Do not ente	er the mode of dyir	ng, such as	cardiac or	respiratory	arrest		Approximat Interval Bet Onset and I	ween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	diac A									
	Examiner				(or as a cons		Dianaa							
		er	Sequentially list conditions, if any leading to immediate	D	or as a cons	Artery	Disease							
V	ate be executed hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	G.										
5	e exe ian ar urial-t	EX	resulting in death) Last	Due to	(or as a cons	equence of):		_						
	cate be executed physician and the burial-transit	dical	ll .	d										
<b>&gt;</b>	The law requires that the death certifics are has been signed by the attending phagge 2 should be detached for use as to	/Me	IF FEMALE:	23c. If yes, ou	toome of pred	nancy						T		
ב	atten for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐Live t	oirth 2 □ Fe nant at time o	etal death 3 🗆	Ectopic pregnancy Other (specify)	/				23d. Date of do Month		Year
;	the d y the ached	ysi	1 □ Yes 2 🖾 No 9 □ Unknown	9□Unkn		r doddir								
,	ires that the de signed by the a be detached f	by PI	Part II. Other significant condition	ns contributing to d	eath but not r	esulting in the ur	iderlying cause giv	en in Part I.		23e. Did	tobac	co use contribute	to the cause of d	eath?
ź	w require been sig should b	ed b	Hypertension,	Mitral Re	gurgit	ation,	Dementia			1 [	] Yes	2∭ No 3∏ F	Probably 4 □U	Jnknown
ָ כ	e law re has be le 2 sho	Completed	Transient Isch	emic Atta	ck					24a. Wa	s an	24b. Were a	autopsy findings	available
	The I	Som									forme	i?   death?		1056 01
AIRC	sician; Th certificate rector, pag	Be (	25. Was case referred to medical examiner?	I I ia-l			la.		of Death (	Check only	one)			
5	Phys this a	၉	1 ☐ Yes 2 X No  27. Manner of Death			☐ ER/Outpatient		4 🗀 NUI				e 6 □Other (Sp	ecify)	
5	ding h. After funer	tion	1 ☑ Natural 5 ☐ Pending		th, Day Year)	injury	Worl	yat k? Yes 2∐1		id. Describe	how i	njury occurred		
2	Atten deat ector: by the	fica	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Place	of injury - At	home, farm, stre	eet, factory, office	100 2		f. Location	(Stree	t and Number or F	Rural Route Num	ber.
5	al or s after al Dire	Certification:	4 ☐ Homicide determin	A buildi	ng, etc. (Spe	city)				City or To	òwn, S	tate)		,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifice completely filled in by the funeral director, particularly filled in by the funeral director, particularly	edical	29a. Certifier 1 ☑ Certifyin 2 ☐ Medical E	hysician: To the aminer: On the b and man	best of my k asis of exami ner stated.	nowledge, death ination and/or inv	occurred at the tin restigation, in my o	me, date and opinion, deal	d place, an	nd due to the	e caus e, date	e(s) and manner a and place, and du	as stated. ue to the cause(s	;)
	To th Withir To th comp	Me	29b. Signature and title of certiller				29c. License	e number			29d.	Date signed (Mor	nth, Day, Year)	
			IM				D055	209			Ма	rch 10,	2008	
	ac		30. Name and address of person w											
	0		Christopher Jol				5 Fernwoo	od Roa	ıd, Sı	uite 5	06	, Betheso	la, MD 2	0817
	Star Registra		31. Date filed (Month, Day, Year) MAR 1 4 20	200	egistrar's Sig	mature	e i							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month **Physician** 02:30 Anna E. Kretzing March 11, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🔀 F 88 Director 511-18-7608 July 13, 1919 Kansas Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Director Rockville Maryland | Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 1125 Parrish Drive 20851 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after ealth and Mental Hygiene. n 27 Is marked other than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: þ 3 X Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrator Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NOT AVAILABLE NOT AVAILABLE Holdeman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 Is a Rena Strauss / Attorney 9210 Corporate Blvd., #390, Rockville, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. March 21, 2008 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Robert A. Fumphrey Funeral Home/Rockville, Inc. M00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or least fillure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ardiac Hriest /Medical Due to (or as a consequence of Examiner Muscordia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE After this certificate has been signed by the attendin funeral director, page 2 should be detached for use. 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 9 Unknown 9 ☐ Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No I or Attending Physician: after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: ဥ 1 | Yes 2 | 106 1 Impatient 2 ER/Outpatient 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending within 24 hours after users...

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 10064560 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ceder Drive Rockille, MD 20850 9901 Medical NIOHI SINGH NIKHANI

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

4

2008

32. Registrar's Signature

			1 - For State Registrar	State of Mi	Ce	rtificate of	Health a Death	and Ment		ne2 ()	08	083	34
	Dhusisi		1. Decedent's Name (First, Middle, L	.ast)					ate of Death	Day	Year	3. Time of Dea	ath
	Physici /Medio		Leopold	C.	Krimme	elbein,	Jr.		rch 11			7:10a	М
	Examin		4a. Facility Name (If not institution, g.	,		4b. City, Town,	or Location of	of Death		4c. County	ol Death		
			North Arundel	Rehab		Glen I				Anne	Arund	e1	
	Funeral		· ·	Sex 7. Ag	e (In yrs. last birthday,	Months Days			ate of Birth fonth, Day, Y	ear)	9. Birthplac	ce (State or Fo	oreign
	Director		212-12-2826	TELM ZUP	87 Yrs.				t. 3,		Maryl		
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation					100	. Inside City L	imits
	lanyl.	ត									1	1 Yes 2	
	the N	ect	Maryland Anne Ar	undel	Linthicu	10f. Zip Code		-	100	. Citizen of W	Ihat Causta		Z
	with a or	គ	37 Mansion Road				`				mai Country	, t	
	ns 23	Funeral Directo	11. Marital Status	12. Was Decedent	Ever in It S 12	21090		nin? (Specify )		USA	- American	Indian	
	ter d	ä	1 ☐ Never Married 2 Married	Armed Forces?	No.	Was Decedent of If Yes, specify Cul	ban, Mexican,	, Puerto Rican	, etc.)		k, White, etc		
99	irs al	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2√√ No	Specify:			Specify:	Wh	ite	
ğ	filed within 72 hours after deeth with the Maryland Hygiene. other than "natural", or Heme 23e or 28e-f ahow int, the Medical Examinat remained at	ed	15. Decedent's I	Education	16a. Dece	dent's Usual Occu	pation		16	b. Kind of Bu:	siness/Indu	stry	
5	in 7	Completed	(Specify only highest g Elementary/Secondary (0-12)		(Give	kind of work done DO NOT use retin	during most ed)	t of working				,	
2	y with	E	12	College (1-4or 5		Preside	nt		т.	. Tay1	or Co	mnanv	
פ	othe	BeC	17. Father's Name (First, Middle, Las	st)				r's Name (Firs				мрану	
ā	Ald be Aenta Akad Ifc a	To B	Leopold	Charles	Krin	melbein	Mary	7 M	argare	t	Kess1	er	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours atter deeth with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f ahow any figury or other traumatic avant, the Medical Examinant per notified at ances.		19a. Informant's Name/Relationship			ing Address (Stree	t and Number	or or Rural Rou	te Number, C	ity or Town, S	State, Zip C	ode)	,
Σ	alth a		Alverta M. Krimme	elbein (Wif	(e) 37 n	nansion R	d., Li	inthicu	m, MD.	21090			
ē,	S 1 a		20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other pla	ace)	Date	20	c. Location - 6	City or Towr	n, State	
Ë	Page ient c nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Loudon Pa			3/14/08	Ba	1timor	e. Ma	rvland	
altimore,	mit. Sertm Sorta 'Inju		21. Signature of Funeral Service Lice	ens		2 Name and Addr							
ñ	Ped in a go		10			620 Wilk							
			23a. Part1. Enter the disease, or co	mplications that caused	the death. Do not en						A	pproximate	
	Physician		shock, or heart lailure. List ont									iterval Betwee Inset and Deat	th
	/Medical		disease or condition resulting in death)	a. M400	a consequence of):	- INIP	nac/	110 KJ				1100	~
	Examiner		1	,	. ,	<b>.</b>			M-1		7		
Ļ	,	e	Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):	0116	7 22 17	7 101	10360	un		cyr	-
$\sqrt{}$	d ansit	Ē	cause. Enter Underlying Cause (Disease or injury that initiated events			,,,,,,		`					
<u> </u>	exec in en ial-tr	Examin	resulting in death) Last	c. Due to (or as									
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89	ficat phy sphy sth	ü		d.	a consequence of);								
		edicai		d.	a consequence of):								
ŏ	anding use a	n/Medic	IF FEMALE: 23b. Was decedent pregnant	d. 23c. Il yes, outcome	of pregnancy	Te			_	23d. Date	of delivery		
Вох	death certific e ettending pl d for use as t	iclan/Medic	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	of pregnancy 2 Petal death 3	□Ectopic pregnand	су			23d. Date Mon		ay Year	
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DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of M	arylar		artmeni <i>rtificate</i>			d Mental		Eu O	38	08335
			Decedent's Name (First, Middle	, Last)					- Outil		Reg. of Death			3. Time of Death
	Physic /Medi		DOROTHY	YOUNG KT	RKS					Marc	h 11	Day 2008	Year	4:30 P. M
	Exami		4a. Fecility Name (If not institution				4b. City,	Fown, or l	Location of D			4c. County		7.30 1.
	Funeral Director		Manor Care Tow 5. Social Security Number 215-16-6437		ge (In yrs. 88	. last birthday) Yrs.	If Under Months	Tows	If Under 24		h. Dev. Yo			ce blace (State or Foreign htty) ginia
	pu .		Usuel Residence of Decedent  10a. State 10b. County		100 C	ity, Town or Lo								
	sho	ō			100.01									10d. tnside City Limits
	the A	Director	Maryland Balt  10e. Street and Number	imore		Towson	10f. Zip	Code			100	. Citizen of V	VID-A COU	1 Yes 2 No
	3a or	0	409 Virginia A	venue Apt.	423		roi. Zip		1286		log		S.A.	,
	death ms 2	Funeral	11. Marital Status	12. Was Decedent	Ever in L	J.S. 13. V	Was Deced			? (Specify Yes	or No-			can tndian,
920	be filed within 72 hours after death with the Maryland ital Hygiene. ud other than "natural", or Items 23a or 28a-f show event, the Madical Exemiting must be notified at	by	1 Mover Married 2 Marri 3 Widowed 4 Divorced	Armed Forces:  1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No		fYes, spec 1☐Yes 2		, Mexican, P Specify:	uerto Rican, etc	;.)	Specify	k, White, : Wh	etc. nite
5-0	72 ho	etec	15. Decedent (Specify only highes	s Education grade completed)		16a. Deced	dent's Usua	Occupat	ion iring most of	working	168	b. Kind of Bu	siness/In	dustry
121	within ene.	Completed	Etementary/Secondary (0-12)	College (1-4or	5+)	life. I	JO NOT US	e retired)				_		
22	e filed within al Hygiene. other than 'vent, the Mu		17. Father's Name (First, Middle, L	2 years			Sup	ervi		NI (6"1 44	2444		iranc	e
and	uld be f Wentai h irked of	Be c	Harry Jacob Ki							Name (First, M			θ)	
7	should ind Men i marke umatic	ဥ	19a. Informant's Name/Relationsh			19b. Mailin	n Address	(Street ar		Louise			State 7in	Codel
S	C		Nina Jean Kamer		(bae	1 223				pt. 423				01006
re,	is 1 a of Hear Item othe		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nam	e of		Date Date		WSOn, c. Location -		Marin Carlot
Ē	Ly Page 1	l l	1 🔀 Burial 2 □ Cremation `4 □ Donation 5 □ Other (Sp		1	rkwood			1	3-17-08	F	Baltim	ore.	Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once.		21. Signature of Funeral Service L	icensee		22 N	Name and litche	Address LI-W	of Facility liedefe	eld Fune Balti	eral	Home.	Inc	21212
			23a. Part1. Enter the disease, or a shock, or heart failure. List of	complications that caused	the deat	th. Do not ente	er the mode	of dying,	such as car	diac or respirate	ory arrest,	, Mary.	Land	Approximate Intervat Between
60,	Physician /Medical		tmmediate Cause (Finat disease or condition resulting in death)	a. Dive to (or as	~~	quence of):								Onset and Death
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	D #	Examiner	If any, leading to immediata cause. Enter Underlying	Dixe to (ar as	s consaq	juanca of):			·					
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.O. Box	The law requires that the death certi ate has been signed by the attending page 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	ıl death 3 🗌	Ectopic pre Other (spe					23d. Date Mor		ory Day Year
<u>a</u>	that the by detail	y Ph	Part II. Other significant condition	s contributing to death b	ut not res	ulting in the un	derlying ca	use given	in Part I.	23e.	Did tobac	co use contri	ibute to ti	ne cause of death?
Vital Records,	quires n sign uld be	ed by	Lyphosis								1 🗌 Yes	2 🗆 No	3 🗌 Prob	ably 4 dunknown
000	s been sign	Completed	, ·							24a.	Was an	24b. W	/ere auto	psy findings available
Ä	Physician: The law r this certificate has ral director, page 2 a	E								-   ;	autopsy performed es 2 2	12 8	rior to coi eath?	npletion of cause of 2⊠No
<u>m</u>		BeC	25. Was case referred to medical examiner?					- 2	26. Place of (	Death (Check o		NO	185	2E1 NO
	hysic his ce I dire	2	1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2	ER/Outpatient	3 🗆 DOA	Other:	4 Nursin	g Home 5□	Residence	6 Othe	r (Specify	")
Division of	I or Attending Phater death. Director: After the in by the funeral		27. Manner of Death  1 Natural 5 Pending  2 Accident investigation		ry v Year)	28b. Time of Injury	28 M	c. Injury a Work? 1  Ye				nju <b>ry</b> occurre		
Š	Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certific tely filled in by the funeral director.	Certification:	3 Suicide 6 Could no 4 Homicide determin		ury - At ho c. <i>(Specif</i> y	ome, farm, stre	et, factory,	office		28f. Locati City o	on (Street r Town, S	t and Numbe tate)	r or Rura	l Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical	one)	Physician: To the best caminer: On the basis of and manner sta	examina	wiedge, death tion and/or inv	estigation, i	n my opir	ion, death o	ace, and due to courred at the ti	the cause me, date	e(s) and mar and place, a	ner as st	ated. the cause(s)
	To To	2	29b. Signature and title of certifier	0.1			29c.	License r	number	1	29d.	Date signed	(Month,	Day, Year)
	11			ve mi				DY	1100	1		2/1	5/	08
	H		30. Name and address of person w	ND. 740	2	jork	Roa	4 6	+301	-, Toz	vser	a del	12	204
ię.	Sta Registra	_	31. Date filed (Month, Day, Year) MAR 1 4 200	8 32. Registra	ar's Signa	ture	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 4:40 AM Bernice Wiernasz Krajewski March 13, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2X F Director 046-22-1162 June 8, 1926 Connecticut Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2X No Director Bel Air Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 East Ring Factory Road 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒No Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinest Marine Hardware 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Joseph Andrew Wiernasz <u> Anna Eliz Augustine</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcia A. Hogan / Daughter East Ring Factory Road, Bel Air, Maryland, 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Calvary Cemetery 3/17/2008 Middletown, Connecticut 21. Sonature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland, 21009 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each lie. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) schemic bou **Physician** /Medical Due to (or as a consequence of): 0515 **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to lor as a consequence of Examine physician and Due to (or as a consequence of): State WSKI, BETNICE M 800488 Division or Wtal Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas certificate l 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1
Yes 2
☐ No 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending | within 24 hours after death. To the Funeral Director: After Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

10

JULIE 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32 Registrar's Signature

TINNEY

29c. License number

D53186

615 W. McPhail Road Bel Air, MD 21014

29d. Date signed (Month, Day, Year)

March 13,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Nn 2608 March 12 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner IS altimore
If Under 24 Hrs. 8. Date of Birth
(Morith, Day, Year) lizabeth Nursing Center If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X**] M 2□ F Months Days 95 Yrs. Director 218-01-2828 1913 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show or other traumatic event, the Madical Examiner must be nutilised at Director 1 ☐ Yes 2 🕅 No Maryland Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or items 23a or 3538 Church Road 21043 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ₹ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ₹ No Specity: Specify: ģ 3 ☐ Widowed 4 🏋 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene.
7 is marked other than \*r Elementary/Secondary (0-12) College (1-4or 5+) 12 years Logistictian Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Menia Important: if item 27 is marked any injury or other traumatic events. 2 Mary Grace Lyons Charles Vincent Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3538 Church Road Ellicott City, Maryland 21043 Charles T. Lacey (nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-15-08 Baltimore, Maryland New Cathedral Cemetery 21. Signature of Funeral Service Licensee Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ears emen /Medical Due to (or as a consequence of) fibrillation Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated experts.) Due to (or as a consequence of): Examine physician and s the burial-transit 100t resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cencer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? (anc 24a. Was an performed? res 20 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Tes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of D\_ath 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: After or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

Benson

32 Registrar's Signature

venue

29c. License number

29d. Date signed (Month, Day, Year)

Worch 12

Maryland

timore

		1 - For State of Registrar	Maryland / Depa	artment of F		-	giene Reg. No. 200	8 08338
Physicia		Decedent's Name (First, Middle, Last)	ocke			2. Date of De- Month March	ath	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give street and numb 615 N. Curley Street		4b. City, Town, o		eath	4c. County of	
Funeral Director		211–18–2049 ¹□M 2√2F	Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days		lin. 8. Date of Birt (Month, Da March 3	0 , 1924	Birthplace (State or Foreign Country)  PA
Maryland -f show fled at	tor	Usual Residence of Decedent  10a. State 10b. County  MD	10c. City, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
vith the	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of Wha	at Country?
death v	Funeral	615 N. Curley Street  11. Marital Status  12. Was Decede Armed Force		Was Decedent of H		' (Specify Yes or No uerto Rican, etc.)	USA 14. Race -	American Indian,
ours after ral", or ite Examine	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give Year or Date	I <b>X</b> No	1 ☐ Yes 2 ☑ No		derio nicari, etc.)	Specify:	White, etc. White
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Important: If them Z7 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4	(Give	dent's Usual Occup kind of work done DO NOT use retired nemaker	eation during most of d)	working	own ho	·
uld be filed Mental Hyg Irked other Itic event,	To Be C	17. Father's Name ( <i>First, Middle, Last</i> ) Lloyd Weaver	<u> </u>			Name <i>(First, Middle,</i> Artha Ke		
id 2 sho ith and 1 7 Is ma trauma		19a. Informant's Name/Relationship (Type. Print) Trudy St.Lawrence/da		-		Rural Route Number		
ges 1 and to f Heal	Ì	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	20b. Place of Dispo		-	/12/08	20c. Location - Cit Rossvi	y or Town, State
oermit. Pa Departmen Important: any injury once,		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee				·		alto. MD sex 21221
		23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	sed the death. Do not ent	ter the mode of dyir	ng, such as care			Approximate Interval Between Onset and Death
Physician /Medical Examiner	£.	COP	as a consequence of):	mg pisa	ess			
cate be executed physician and k	dical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events c.	as a consequence of):					
atth certifi attending   for use as	Physician/Med		h 2 □ Fetal death 3 □ It at time of death 5 □	Ectopic pregnancy Other (specify)	/		23d. Date o	,
law requires that the disable been signed by the a	by	Part II. Other significant conditions contributing to deat  Courny Autor Juscese, J	h but not resulting in the u	nderlying cause giv Letts , Hy	en in Part I. Devlersn	23e. Did to		ute to the cause of death?
10 1	Completed	pulsonay Hyperterm,				24a. Was autor perfo 1∐ Yes	rmed? pric	re autopsy findings available or to completion of cause of th?  Yes 2 No
Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ⑤ Inp	atient 2 ☐ ER/Outpatier	ot 3 DOA Oth		Death <i>(Check only o</i> g Home 5 <b>∑</b> Resid		(Specify)
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	$\vdash \neg$	27. Manner of Death 28a. Date of		f 28c. Injur Wor			now injury occurred	Specify
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of building	injury - At home, farm, str , etc. (Specify)	reet, factory, office		28f. Location (S City or Tou		or Rural Route Number,
ne Hospi n 24 hour ne Funer	Medical (	29a. Certifier (Check only one) Certifying Physician: To the be 2 Medical Examiner: On the basi and manner	s of examination and/or in	h occurred at the til vestigation, in my o	me, date and pl opinion, death o	ace, and due to the occurred at the time,	cause(s) and mann date and place, and	er as stated. d due to the cause(s)
To th within	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signed (	_
6	-	30. Name and address of person who completed cause of	of death (Item 23a) (Type,	Print)	, 16 X		3/10/08	
Stat	to.	ROBERT LIBUTE, MD. 3505 31. Date filed (Month, Day, Year) 32. deg	BANK ST	Baltr,	Mul ?	21224		
Stat Registra		MAR 1 4 2008	EURI St. P.	Jan Marie				

		For State Registrar		State of	Maryland		artment of F ertificate of				giene , Reg. No. <sup>Z</sup>	2008	0833	39
Physicia /Medic			ne (First, Middle, La. Edward Low	,						2. Date of Dea Month	Day	Year 2008	3. Time of Death	
Examin Funeral Director	er			re Hospi				e da	ا و er 24 Hrs.	8. Date of Birt (Month, Da UNC 4,	13c			eign
aller effet	or	Usual Residence of 10a. State Maryland	f Decedent  10b. County  Baltimor	e	10c. City	, Town or L	ocation timore						10d. Inside City Lim 1 ☐ Yes 2 ☑	
23a or 28a- ıst be notif	al Directo	10e. Street and Nu					10f. Zip Code 21234	ļ			10g. Citize	n of What Co	untry?	
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1  □ Never Mari 3  □ Widowed	ried 2 <b>∑√</b> Married 4 □ Divorced	12. Was Decedo Armed Force 1 TY'es 2 If Yes, Give Year or Date	es? □ No <b>WWII</b>	S. 13	. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☒ No	lispanic C an, Mexic Specify		cify Yes or No Rican, etc.)		. Race - Ame Black, White pecify: W		
jiene. r than "natu the Medical	Completed	(Spec	15. Decedent's Educify only highest gra	ducation ade completed) College (1-4	or 5+)	(Giv life.	edent's Usual Occu le kind of work done DO NOT use retire ulator	ation during mo d)	ost of workin	g		of Business/	•	
Mental Hyg larked other	To Be C	Carl M. L				1		В	essie \	(First, Middle,	ner			
f Health and Item 27 is m other traum	31.	Bill C. Lo	sposition		20b. P	3503	ling Address (Street  Quatman Aveosition (Name of ematory or other pla	enue	Baltimo		land 2			
spartment o sportant: If y injury or	1	4 Donation	Cremation 3 ☐ 5 ☐ Other (Special Service Lice	fy)	Par	kwood	Cemetery 22. Name and Address 5305 Harfor		3/17/0 IInc			imore, M	laryland	
hysician /Medical xaminer	ner	23a. Part1. Enter shock, or her immediate Cause disease or condition resulting in death)  Sequentially list or if any, leading to in cause. Enter Und. Cause (Disease of Cause) (Disease of Disease)	onditions.	plications that cau	sed the death th line.	n. Do not e		ng, such a	as cardiac or	respiratory a		21214	Approximate Interval Between Onset and Death 24 hou	162
ing physician and eas the burial-transit	Medical Examiner	Cause (Disease or that initiated event resulting in death)	ts 🔳	CDue to (or	as a consequ	uence of):								
by the aftend ached for us	Physician/M	23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknown	2 months?		h 2∐Feta nt at time of d	I death 3	□Ectopic pregnanc □ Other (specify) _	У			23	d. Date of del Month	Day Year	
sen signed I	þ	Pneum	ificant conditions	clostr	diu	m d	ifficul.	e					o the cause of death' robably 4	
rificate has b	Be Completed	Hemc 25. Was case refe	erred to medical		3 C Re	enal	DISEASE	26. Pla		24a. Was auto perfo	psy ormed? 2 No	24b. Were as prior to death? 1 □Yes	utopsy findings availa completion of cause s 2 □ No	able of
within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending p completely filled in by th∈ funeral director, page 2 should be detached for use as:	Certification: To B	examiner? 1   Yes 2   27. Manner of Dea 1   Natural 2   Accident 3   Suicide 4   Homicide	ath 5 ☐ Pending investigatio 6 ☐ Could not b	28a. Date of (Month)	Injury Day Year)	28b. Time Injury	of 28c. Inju	ry at rk? ] Yes 2[	□No 2		how injury	occurred	ural Route Number,	
in 24 hours the Funeral	Medical C	29a. Certifier (Check only one)	2 ☐ Medical Exa		is of examina		ath occurred at the tinvestigation, in my	opinion, o	leath occurre		, date and p	place, and du	e to the cause(s)	
w P Som	Σ	29b. Signature and	dress of person who	completed cause	of death (Item	1 23a) (Tun		se numbe			29d. Date	signed (Mon	th, Day, Year)	
Sta Registi		DR Cassa	indra u	Villiam S		FR	ANKLIN S	qua	rec	OR BO	aLTO	md	21237	7

			For State Registrar	State o	f Marylan		artment <i>rtificate</i>			d Mei	ntal Hy	giene	20	0.8	08340
F	Di vivi		1. Decedent's Name (First, Middle	le, Last)						2.	Date of D	eath	<u> </u>	Voor	3. Time of Death
	Physici /Medi		Kwang-Tzu			Lι	1			M	larch	12, Day	200	Year 8	3:45 P. M
4	Examir		4a. Facility Name (If not institutio	n, give street and nu	mber)		4b. City, To	own, or L	ocation of D	eath		4c.	County	of Death	
	54	2	19605 Stewartov				Gaitl					Mo	ntg	omery	
ì	Funeral Director		5. Social Security Number 335-42-2014	6. Sex 1 X M 2 □ F	7. Age (In yrs. 66	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hours	/lin.	Date of Bi (Month, D ay 15	lav. Year)	41	9. Birthp Court Chir	
	and w		Usual Residence of Decedent  10a. State 10b. County	,	10c. Cit	y, Town or Lo	ocation							1	0d. Inside City Limits
	he Maryl 8a-f sho otified a	Funeral Director		gomery	Gai	thersl									1 ☐ Yes 2 📉 No
	with t	ä	10e. Street and Number	-			10f. Zip C							What Cour	•
	eath is 23 must	eral	19605 Stewarton		edent Ever in U.	C 12		0879		2 (Casaif	. Von or N			Stat e - Americ	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28e-f show or other traumatic event, the Medical Examiner must be notified at	۾	11. Marital Status  1 ☐ Never Married 2 ☐ Mar  3 ☐ Widowed 4 ☐ Divorced	ried Armed Fo	orces? 2 X No ve		Was Decede If Yes, specif 1 ☐ Yes 2	17	Specify:	uerto Ric	an, etc.)	0-		ck, White,	etc.
9-0	72 ho natur lical I	Completed	15. Deceder	nt's Education est grade completed)		16a. Dece	dent's Usual	Occupat	tion	working		16b. K	ind of B	usiness/Ind	dustry
2	within lene. than "I	ם	Elementary/Secondary (0-12)	College (*	1-4or 5+)		kind of work DO NOT use	retired)	ming most of	WOIKING					
21	ed wi ygier ner th				-	Scie	entist						hys		
Maryland	2 should be filed v and Mental Hygie is marked other t raumatic event, th	Be	17. Father's Name (First, Middle,	Last)					18. Mother's				Surnan	ne)	
2	d Mer narke	ဥ	Fuh-Ting Lu	drie (Torre Dried)	·	405 84-11	4-1-1 //	244	Shen-					01.1.7	
Mai	d 2 st th and 7 is r traur		19a. Informant's Name/Relations Shau-Zou Lu/Bro				ng Address (S Grafton								Code)
	1 and 2 Health tem 27 i		20a. Method of Disposition	Jener	20b. F				-			_		City or To	wn, State
no	Pages nent of h unt: If ite		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		State Moi	Place of Dispo cemetery, cre ntgome cemato:	matory or oth ry	er place,	Ma	rch 2008	15,			da, M	
Baltimore,	+ E # = .		21. Signature of Funeral Service		01	3	2. Name and	Address			rt A.				neral Home nsin Ave.
ä	Depar Depar Impor any Ir		100/2	811	M01	.346	Betheso	la-C	MD 208	nase 314	, Inc	c. /3	007	wisco	nsin Ave.
	7 10		23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that of	caused the deat	h. Do not en	ter the mode	of dying	, such as car	diac or re	espiratory	arrest,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ci.	CInos	ma L	350	0	Gd-	an o	٥~			1	Onset and Death
4	/Medical		resulting in death)		(or as a conseq				200	1011				_	10116
**	Examiner		Sequentially list conditions,	b								_			
7	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence of):									
V _	xecut and Il-tran	Examiner	that initiated events resulting in death) Last	c	(or as a conseq	uence of):									
8760,	cate be executed oblysician and the burial-transit	dical E			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,									
9	ficate g phys is the	edic		d											
O. Box	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live t	tcome pf pregna pirth 2 Peta nant at time of d own	death 3	⊒Ectopic preg ⊒ Other <i>(spec</i>							te of delive	ery Day Year
Δ.	res that signed by be deta		Part II. Other significant conditi	ons contributing to de	eath but not res	ulting in the u	nderlying cau	se giver	n in Part I.		23e. Did	tobacco	use cont	ribute to th	ne cause of death?
rds	w requires been sign should be	d by				_				_	1 🗆	Yes 2	□ No	3 Prob	ably 4 Unknown
တ္တ	S D S	Completed									24a. Was		24b.	Were auto	psy findings available
Ä	e 7 e	шо								_		opsy formed? 2 <b>2</b> No		death?	inpletion of cause of 2 □ No
İta	slcian: Th certificate rector, pag	0	25. Was case referred to medica	ıl					26. Place of	Death (C			<u></u>	100	
or Vital Records,	dir	To B	examiner? 1 Yes 2 No	Hospital: 1	Inpatient 2 🗆	ER/Outpatie	nt 3□ DOA	Other	4 ☐ Nursir	ng Home	5 Res	sidence	6 □Oth	ner (Specif	y)
ion o	ing Affer une		27. Manner of Death  1 Natural 5 Pendir 2 Accident investi	19 1 '	of Injury th, Day Year)	28b. Time o Injury	f 280	injury Work? 1 ☐ Y	at es 2 □ No	28d	. Describe	how inju	ry occur	red	
Division	i Dir	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 200. Place	of injury - At ho ing, etc. (Specif	ome, farm, str	reet, factory,	office		28f.		(Street ar own, State		per or Rura	l Route Number,
	pital urs a eral	2	On Continu	Dhualaian Taith	bankatan lua							,			

n: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D 22478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2101 Medical Park Drive, #304, Silver Spring, MD 20902-4053 Ira N. Brecher, M.D., 31. Date filed (Month, Day, Year)

State Registrar

State of Maryland / Department of Health and Mental Hygiene 0834 Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 03-11-2008 2324 Mary M. Lynch /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** Cecil Sunbridge Rehab and Health Elkton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03-24-1912 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Months Days Hours 1□M 2√2F 95 Yrs. Director 212-05-1746 Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Meryland. Department of Health end Mental Hygiene. Important: If Hem 27 is marked other than "natural" ~ any injury or other traumetic even. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No E1kton Funeral Director Maryland Cecil 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21921 141 Breon Lane 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Telephone Operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Julia Ann Ziomek Francis Beksinski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 141 Breon Lane Elkton, MD 21921 Patricia A. Pannill (Daughter) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date etery, cremetory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stanislaus Cemetery 3-15-08 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) RESPIRANCE Examiner Due to (or es a consequence of): Physician/Medical Examiner SEPSIS or Attending Physician: The law requires thet the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Hyperlens woo

Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Atter this certificate hes been signed by the attending physician funerel director, page 2 should be deteched for use es the burie Rend Insubbicany 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of deeth? 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical 26. Place of Death (Check only one) B Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Naturel 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendition within 24 hours effer death.

To the Funeral Director: A 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier brushan 5 D 0065733 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NARAYANA RAS. V. PULA sute 21921 38 NORTH Smeet ELIKION MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 MAR 14 Saper A Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) CHRISTINE McCONDICHE 2. Date of Death **Physician** 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore FRANKLIN SQUARE HOSPITAL CENTER Rosedale If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Director AL 4/6/37 10b. County 10c, City, Town or Location 10a. State 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at MD N/A 1 ☐ Yes 2 ☐ No Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1049 St. Marlyn Ave

Il Status

ever Married 2 Married | 12. Was Decedent Ever in U.S. Armed Forces? | 1 | Yes 2 | No | If Yes, Give X | Year or Dates: USA by Funeral 21221

13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospital Nursing CNA 10 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Joseph Carstarphen Julia King 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1313 Nautica Circle, Essex, MD 21221 Danielle Lamothe/Daughter Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 3/19/08 4 Donation 5 ☐ Other (Specify) Getshene Cem Mobile, AL 22. Name and Address of Facility Hari P. Close F. Svs, PA 21. Signature of Funeral Service License 5126 Belair Rd, Balt., MD 21206 23a. Part1. En enthe disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death RESPIRATORY FAILURE Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of):

LUNG CANCER /Medical Examiner Sequentially list conditions, if any, leading to intrinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 🕉 Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of Injury 28h Time of 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29h Signature and title of certification 29c. License number 631076

State Registrar

31. Date filed (Month, Day, Year)

MAR 14

CCON DIC

30-Name and address of person who completed cause of death (Item 23a) (Type, Print)

OPEN ELIASION M., ALOGOPHICA DECPITIA Na., Amerimone, MD 21237

31. Date filed (Month, Day, Year)

MAR 1 4 2008

38. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend #23b Per Phy G877 3/10/4/10/9/icalle of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 **Physician** 20ď8 6:16 A Jean Morin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Exeter Road ean worcester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8-7-1934 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2 🕱 F Director 215-32-2230 Honold Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Worcester 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? oad Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) tome Tomemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ ser Margaret ra 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Morins Maryland 21842 Exeter Koad Ocean Cit 20b. Place of Disposition (Name of cemetery, crematory or other place)

Park Cemetery

22. Name and Address of Facility

Luans Funeral Ci 20a. Method of Disposition Date 20c. Location 1 Burial 2 □ Cremation 3 □ Removal from State 3/13/2008 4 □ Donation 5 □ Other (Specify) timore Maryland 21. Signature of Funeral Service Licensee apel & Cremation Services - Parkuille V 8800 Harford Road Parkville Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pul monay /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknow signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed: 1∐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 No 27. Manner of Death 1 | Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 2 After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident Injury within 24 hours after deau..

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 40053714 30. Name and of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Franklin

32. Registrar's Signature

matriani

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** John E. McLaughlin Month Year  $p_{M}$ 2:05 March 9, 2008 /Medical 4c. County of Death Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince Frederick Calvert Memorial Hospital Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Months 1**№**M 2□F 77 151-24-4748 12/10/1930 Director NY Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at Director MD Calvert Lusby 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20657 Bay USA 11315 Front Avenue Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
Then of Health and Mental Hygiene.
This marked other than "natural", or items 23s ints: If item 27 is marked other than "natural", or items 23s inty or other traumatic event, the Medical Examiner muss? Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 📆 No White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Give kind of work done during most of working life. Da NOT use retired.
Supervisor of Letter Carrier Postal Operations Elementary/Secondary (0-12) College (1-4or 5+) Post Office 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John McLaughlin He1en Jermyn ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11315 Bay Front Avenue, Lusby, MD 20657 19a. Informant's Name/Relationship (Type. Print) Joan McLaughlin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once, 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Gate of Heaven 3/14/2008 East Hanover, NJ 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc. 21. Signature of Funeral Service Licenses Jorets 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE EXACERBATION disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** TOBACCO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Physician/Medical the as attending properties of the second 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SIGGD OBSTRUCTIVE BONGA 1 Pres 2 No 3 Probably 4 Unknown Be Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate ACUTE FAILURG 2 ☐ No MRONIC 1□ Yes 2 No 1 TYes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

ospital or Attending Physician: hours after death. Ineral Director: After this certifica within 24 hours at To the Funeral D Hospital

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one)

29b. Signature and title of certifier

D0064961

SVITE

29c. License number

ROAD

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AM388FWA 110 MOSDIADI

NT

31. Date filed (Month, Day, Year) MAR 1 4 2008

32. Registrar's Signature relativas

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08345 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Physician Month Anthony James Mastro March 6, 15:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda

||FUnder1Year | ||FUnder24 Hrs. | 8. Date of Birth (Month, Day, May 12, May 12, Suburban Hospital Montgomery 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** New Jersey 82 150-16-3891 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at show 1 ☐ Yes 2X No Director Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be r 9605 Kentsdale Drive 20854 United States Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygiene. Important: If frem 27 is marked other there any injury or other trainment. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: \ 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: White þ Snecify: 3 Widowed 4 Divorced WWIT Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Professor Emeritus University 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Luciano Mastrogiovanni Giusepphina Orrico 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian A. Mastro/Son 9605 Kentsdale Drive, Potomac, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 12. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cemetery Silver Spring, Maryland 21. Signature of Funeral Service License Robert A. Pumphrey Funeral Home, Rockville, Inc. Ulldan a M01173

Physician /Medical

death with the Maryland

Examiner

attending physician and for use as the burial-tran

been signed by the should be detached

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certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

ours after death.

reral Director: A
filled in by the fu

Completed

Be

2

Certification:

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner IF FFMALE: 23b. Was decedent pregnant in the past 12 months? 1 ∏Yes 2 ∏No 9 Unknown þ

Immediate Cause (Final

disease or condition resulting in death)

23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death
9 □ Unknown

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

Chronic Obstructive and Restrictive Pulmonary

Disease

D52451

23d. Date of delivery Day

March 11, 2008

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown

Year

Approximate Interval Between Onset and Death

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure

determined

29b. Signature and title of certifier

24a. Was an autopsy performed? Yes 20 No 26. Place of Death (Check only one)

300 W. Montgomery Avenue, Rockville, Maryland 20850

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Michael a. Westerman 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael A. Westerman, M.D. P.O. Box 2316, Kensington, Maryland 31. Date filed (Month, Day, Year)

State Registrar

32. Registrar's Signature 4

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2008 Mattison March 6, 1:00 Maxine В. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care Potomac Potomac Montgomery 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗓 F 431-07-9261 93 Director July 25, 1914 Arkansas Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d, Inside City Limits r 28a-f show notified at 10b. County 1 ☐ Yes 2 X No Directo Maryland Montgomery Potomac 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or 10714 Potomac Tennis Lane 20854 United States ms 23a Funeral "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Armed Forces?

1 ☐ Yes 2 🕅 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗓 No Specify: ģ 3 Widowed 4 □ Divorced Completed er than "natur the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Barron Sarah Lewis ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2539 Bedford Street, Unit 37D, Stamford, CT 06905 Stanley B. Mattison / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 11, Important: If it any injury or o 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Metropolitan Crematory 2008 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shogk, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immedia e Cause (Final Physician END STAGE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) ed by the 1 ☐ Yes 2 D No 9□Unknown 9 Unknown signed d be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes → No 24a. Was an page 2 s autopsy performed? res 2 No certificate the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 202 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident Funeral Director: itely filled in by the 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00057124 Luca/scro, MD 317108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Center Drive, Rockville, Maryland 20850 Troung Bao, M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 14 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician Month Dav Norman Albert Mrozinski Sr. March 10, 2008 17:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Harford If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Months Hours 1₩ M 2□F Director 78 Nov. 16, 1929 | Maryland 212-26-5940 r 28a-f show notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7 Is marked other than "natural", or items 23a or traumatic event, the M dical Examiner must be r 710 Kings Path Unit 3C 21014 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2√ Married 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 08 | 740 | Maryland 21215 Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 Can Manufacturer Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental F Be 1 and 2 should be Albert Henry Mrozinski Eva (nmn) Kendzinski ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other trai Patricia Mrozinski / wife 710 King Path Unit 3C, Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith 4 Donation 5 Dother (Specify) 3-14-08 Baltimore, Maryland alure of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARRORY DISEASE CORONARY 10 YRS. Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Mrozinski, Norman M800434334 Division or Vital Records, P.O. Box 68760, & burial-tran Due to (or as a consequence of): physician Physician/Medical the attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown by signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 KIDNEY DIZENZA END 57366 should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an certificate has b irector, page 2 st ormedi 2 ☑ No 1□ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 XN0 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

5

State Registrar 29b. Signature and title of certifie

Jason Birnbaum,

31. Date filed (Month, Day, Year) MAR 1 4 2008

29c. License number

00056296

upper Cherapeake Dr. Bel Air, mp 21014

29d. Date signed (Month, Day, Year)

and manner stated.

32. Registrar's Signature

500

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician 0555 AM MOEBUIS 2008 MARCH HWNA /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner GALTIMORE DOHN'S HOALING BAYVIEW MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 16, 1948 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** Mary land Months Days Hours 1 □ M 2√2 F 59 215-46-6728 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 1 No 2 No Baltimore a or 28a-f sh Maryland N/ADirector permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: If then 27 Is marked other than "never any injury or other traumatic any injury or other traumatic and proce. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6308 Danville Avenue 21224 U.S.A. Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give A Black, White, etc. 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 ☐ No Specify 3 ☐ Widowed 4 反 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bartender Tavern 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be White Charles Armstrong Idaပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2426 Holly Neck Road Baltimore, Maryland 21221 Anna M. Moebuis/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 3/17/08 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck F.H. of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NEU MONIA WELL /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖪 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ANTONY THROMBOSIS 24a. Was an certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No I Director: d in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide determined within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifler MO, PHD NES-000 ddress of person who completed cause of death (Item 23a) (Type, Print) AVENUE BALTIMONE, MO OSTIZIN MO COWINS EASTERN 31. Date filed (Month, Day, Year) MAR 14

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 10A.M RICE narch 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE Mossville 055Ville If Under Year | If Under 24 Hrs. Months | Days | Hours | Min. 6. Sex 9. Birthplace (State or Foreign Country) Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months 406-38-0199 1**/2** M 2 □ F Director More head Usual Residence of Decedent 10a. State 10c. City, Town or Location i show 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 1 ☐ Yes 2 No Director TARKUILLE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Ma Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Nes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) là permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygic Important: If item 27 is marked other only Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be uther ဂ MICE reecs 19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street an Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Frankford Ave Baltimore, MD gentry Daughten 4104 Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cometer 15/08 4 ☐ Donation 5 ☐ Other (Specify) Daltimore 21. Signatur of Funeral Service Licenses 22. Name and Add ss of Facility Rd., BALTIMOre, MD 21234 HOLE how Evanstimera Chapital rema e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the diseas shock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Demente sequentially little conform, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed Due to (or as a consequence of): and burial-trar Box 68760, Physician/Medical the SS attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) P.0. the 9□Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed certificate | 1∐ Yes 2 No Division or Vital the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 NO 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 ☐ Pending investigation 1 Natural Injury within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🚅 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1/AmD D31464 08

State Registrar 31. Date filed (Month, Day, Year)

MAR 14

2008

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHOA(13 A. HH) HM I. S2(N. ENTAW ST Finds 308, BALTIMORE MI)

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #8 Per Attorney G8784/118/48 of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 Day Year Physician LIK 17:58 2008 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Universit redicul Center Maryland 8. Date of Birth (Month, Day, Year) 938 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1**%** M 2□ F Country 69 510-38-8808 Director Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Show iral", or items 23a or 28a-f show Examiner must be notified at Baltimore Baltimore MD 1 ☐ Yes 2 XNo Director 10f. Zip Code 21222 10g. Citizen of What Country? 10e. Street and Number 88 Admiral Blvd USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nnt: If Item 27 Is marked other than "natural", or iten 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: White ρ 3 Widowed 4 Divorced Item 27 Is marked other than "natural", other traumatic event, the M-dlcal Exa Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) University of MD Elementary/Secondary (0-12) College (1-4or 5+) Dentist 8vrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eleanor Cunningham William R. Park ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 Portship Road Baltimore MD 21222 /friend William R. Housman 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If It any Injury or c 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 3/14/08 Baltimore MD Bayview Crematory 4 Donation 5 Dother (Specify) 21. Signature of Funeral Selvice Licensee 22. Name and Address of Facility 300 Mace Ave. Baltimore MD Connelly Funeral Home of Essex 21221 e ruch 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resinatory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician 12 days I ravnatic /Medical Due to (or as a consequence of). DICAL Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit certificate be executed FRTIFIC Due to (or as a consequence of): Box 68760, attending physician Physician/Medical ast IF FEMALE: nse 23c, If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. I n signed by the a ld be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by preumothorax 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen facial fractures 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an has autopsy this certificate 1□ Yes 2 7 No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred PASSENGER 27. Manner of Death 28c. Injury at Work? Certification: After 1 □ Natural 5 Pending investigation **₽** M To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No Motor vehicle 2 Accident 2/28/2008 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) D UN LOLK MD 3 ☐ Suicide determined 4 ☐ Homicide German HILL Rd + Merrit Blid 1 ET Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b, Signature and title of certifier 17640 VO 21261 Jeff Zilberstein MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ballimore 5 GIRENR 111) 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State garie

DHMH 17 Rev 1/2001

Registrar

2008

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			Registrar  1. Decedent's Name (First, Middle, Last)	Cei	lineate of L	Jealli	2. Date of De	neg. No o	3. Time of Death
4	Physici		Enzo Anthony Puglisi					13, 2008 Year	2:00 A. M
	/Medio		4a. Facility Name (If not institution, give street and nur	mber)	4b. City, Town, or	Location of Deat		4c. County of Dea	
			Potomac Valley Nursing H	ome	Rockville			Montgomer	у
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir	th 9. Bir	thplace (State or Foreign ountry)
ь	Director		Usual Residence of Decedent	88 Yrs.			Feb. 19	y, Year) 1920 New	York
	land ow		10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary Fied (	to	Maryland Montgomery	Bethesda					1 ☐ Yes 2 📉 No
	th the or 28s e noti	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What Co	ountry?
	tth wil	ral	3 Ardmore Court		20816			United Stat	es
	tems	Funeral	Armed Fo	edent Ever in U.S. 13.1	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puer	pecify Yes or No to Rican, etc.)	14. Race - Ame Black, Whi	
36	filed within 72 hours after death with the Maryland Hygiene. Yher than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notitled at	by F	1 ☐ Never Married 2 ☒ Married 1 ☒ Yes If Yes, Giv 3 ☐ Widowed 4 ☐ Divorced Year or D.	/e TATALT T	1 ☐ Yes 2 ☑ No	Specify:		Specify:	White
9	2 hour	edk	15. Decedent's Education	16a, Dece	dent's Usual Occupa	ation		16b. Kind of Business	
212	hin 72 e. en "ne Media	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1	-4or 5+) (Give life. I	kind of work done o DO NOT use retired	during most of wo	rking		,
2	d wit	Completed	5+	Eco	nomist			U.S. Gover	nment
p	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, Last)			18. Mother's Nar	ne (First, Middle	, Maiden Surname)	
<u>Y</u> a	ould Men narke	입	Joseph Puglisi			Adalgisa			
Maryland 21215-0036	d2strand thand 7 Isn traum		19a. Informant's Name/Relationship (Type. Print)  Christopher Joseph Pugli		-			er, City or Town, State,	
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	12	20a. Method of Disposition	20b. Place of Dispo				20c. Location - City or	
altimore,	0 0	1	1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State Montgomery (			h <sup>Date</sup> 15,	Bethesda, M	
量	# E E E	1.0	21. Signature of Funeral Service License			, =-		ethesda-Chevy	
ñ	permi Depar Impor any Ir		7.2.					sda, MD 208	
ŀ			23a. Part1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Pneu	monia					Onset and Death
	/Medical Examiner		resulting in death)  Due to (	or as a consequence of):					
- 53 - 74	o o	<u></u>	Sequentially list conditions, b. Deme						years
T	ted nsit	Examiner	Cause (Disease or injury	or as a consequence of):					1
	execu al-tra	Exar	that initiated events	or as a consequence of):					
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Box	leath certific attending p	an/I		come pf pregnancy irth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy			23d. Date of de	*
0	the at	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		Other (specify)			Month	Day Year
<u>a</u> :	that the		Part II. Other significant conditions contributing to de	eath but not resulting in the u	nderlying cause give	en in Part I	23e. Did t	obacco use contribute t	o the cause of death?
Records,	A requires that the ditention is since the detached	d by			,g g				robably 4 ⊠Unknown
ò	r req	lete					24a. Was	an 24h Were a	utopsy findings available
<b>£</b>	The law te has bage 2 st	Completed					auto perfo	psy prior to prmed? death?	completion of cause of
Vital			25. Was case referred to medical			26. Place of Dea	1□ Yes ath (Check only o		3 2 No
	ysici iis cer direct	o Be	examiner? 1 ☐ Yes 2 🔀 No Hospital: 1 ☐ I	npatient 2 ER/Outpatien	t 3 DOA Othe			dence 6 □Other (Spe	ecify)
n or	ng Ph fter th neral	T:UC	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Mont	of Injury 28b. Time of Injury	28c. Injury Work		1	how injury occurred	
<u> </u>	tendi eath. tor: A the fu	catic	2 Accident investigation			Yes 2 □ No			
Division	or At or or At or or At or or At or or at or at or at or or at or at or at or at or at or at or at or at or at or at or at or at or at or at or at or at or	Certification:	4 Homicide determined 28e. Place buildi	of injury - At home, farm, str ng, etc. <i>(Specify)</i>	eet, factory, office		28f. Location ( City or To	Street and Number or R wn, State)	tural Route Number,
	spital ours a neral filled		29a. Certifier 1 X Certifying Physician: To the	best of my knowledge, death	occurred at the tim	ne date and place	and due to the	cause(s) and manner a	s stated
	To the Hospital or Attending Physician: whin 24 hours after deals. To the Funeral Director. After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical Examiner: On the ba						
	To th To th comp	Me	29b. Signature and title of certifier		29c. License	number		29d. Date signed (Mon	th, Day, Year)
			1 three of	lugla 1	W) D382	62	1	March 13, 2	008
	1/2		30. Name and address of person who completed caus	, , , , , , ,	,	S 55		200	175
	1	1 1	Anurita Mendhiratta, M.D		rch Blvd.	, #330,	Rockvil	le, Marylar	nd 20850
	Sta Registr		31. Date filed (Month, Day, Year) 32. R	egistrar's Signature					
			THE LATE J. "T A. UUU A. HERREN	THE STREET STREET					

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Agnes M. Polson 2008 4:42 P March 8, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hart Heritage Home Harford Street If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 □ M 2X F Director 381-07-4190 90 11, 1917 Scotland Mar. Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Directo Maryland Harford Abingdon 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number n' of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or ? or other traumatic event, the Medical Examiner must be n 21009 112 Hastings Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours afternent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🏖 ☐ No Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Alexander (nmn) Mackintosh Helen (nmn) Currie ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 Hastings Court, Abingdon, Maryland 21009 Nancy Jo Macfarlane / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Acacia Park Masonic Cem. 3-14-08 Beverly Hills, MI 4 ☐ Donation 5 ☐ Other (Specify) nature of Funeral Service Co 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** Congestive Hesnt 4RANS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate causs. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit and Due to (or as a consequence of): physician Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 | Fetal death in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2□ No 24a. Was an certificate has t irector, page 2 s autopsy performed? 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? As 5.5 fc 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No CARE 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be exec Box 68760, P.O. Division or Vital Records, death. ours after death.

neral Director; / ь within 24 hours at To the Funeral D To the Hospital

death

Baltimore, Maryland 21215-0036

iD

Registrar

Medical

29a. Certifier

AUFRAG 31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANGES

MO

W. Mpclitail RD Bel sin un 21014 615

32 Registrar's Signature 2008 MAR 1

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

739889

29d. Date signed (Month, Day, Year)

MANU 11, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month **Physician** 2008 Theresa Platt larch /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Medical Center Joseph 10WSON If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 06/23/1914 6 Sex 7. Age (In yrs. last birthday, 5. Social Security Number Birthplace (State or Foreign
Country) **Funeral** Months 1 ☐ M 2 💢 F Maryland Director 93 216–18–6718 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 No Director Baltimore Maryland N/A10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21210 United States 5508 N. Charles Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 🎉 No White Specify Specify: Completed by 3X Widowed 4 □ Divorced Year or Dates: "natural", the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **Business Owner** Retail permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked other any injury or other traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Anna Krieger Frank Beran 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland
20c. Location - City or Town, State 111 Hamlet Hill Road #501 <u> Patrick Platt - Son</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 XOther (Specify) Fintantment 03/15/2008 Timonium, Maryland 22. Name and Address of Facility
David J. Weber Funeral Homes P.A.
401 S. Chester Street Baltimore, Maryland 21231 21. Signature of Funeral Service Licens, بمنو Approximate Interval Between Onset and Death Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition 1, seuse **Physician** (OTONNY resulting in death) /Medical Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ⚠ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ins certificate has been signed director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy 2 No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 XER/Outpatient 3 DOA this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director; 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2. 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Osler Drive Towson Maryland 21204 P. Hi-para Jayant 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

that the death certificate be executed P.O. Box 68760 Division or Vital Records, Hospital or Attending

burialphysician s the burial attending p nse for ed by the a detached i signed to cate has been signated bage 2 should b certificate director, this funeral c After within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

**Funeral** 

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

the

Department of Health and Mental Hygis Important; If Item 27 is marked other i any Injury or other traumatic event, tt

**Physician** /Medical Examiner

1 and 2 should be

Maryland 21215-0036

6 ☐ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier Pom. 1 P. Cley W.

D14314

1 ocrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) march (2,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. KLUG. 145 E Canoll street, Salisbury, Md. 21801

Registrar

Medical

31. Date filed (Month, Day, Year)

32. Registrar's Signature

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., g877,03/14/08dhb and Mental Hygiene
Amend Item 23a per dr., g877,03/14/08dhb

Reg. No. 03/09/2008 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 200 Virginia Oueen Marie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Nov. 24, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) Days 1 □ M 2 🗓 F 412-90-8758 56 1951 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show be notified at 1 ☐Yes 2 ☑ No Director MD Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a injury or other traumatic event, the Medical Examiner must be by Funeral 418 Hill View Drive 21090 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. of Health and Mental Hygiene. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Agility H.R. Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Herbert Whittaker Helen Irma Ricks ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12 Cedar Hill Road Baltimore, Maryland 21225 Barbara Hullihen 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 14 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Pages 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2008 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licenses mov918 ▶. Services 1 2nd Avenue S.W. Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Pneumonia 21/6/10/ /Medical (or as a consequence of): Examiner myolandis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of) Examine Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy certificate To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one Hospital: Inpatient 2[
28a. Date of Injury
(Month, Day Year) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Deat 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 03/09/2008 29b. Signature and title of certifier 29c. License number of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State 2008 4 Registrar

Examiner executed Division or Vital Records, P.O. Box 68760,

physician and s the burial-trans The law requires that the death certificate be as t use for ned by the a signed b has page this certificate or Attending Physician: director After within 24 hours after death.

To the Funeral Director: /
completely filled in by the f Hospital

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

iral", or items 23a or 28a-f shov Examiner must be notified at

"natural"

Pages 1 and 2 should be filed within 72 homent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natuury or other traumatic event, the Medical.

Department of h
Important; If Ite
any Injury or of

**Physician** /Medical Director

Funeral

Completed by

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Examiner

Physician/Medical

Completed by

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Certification:

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DONELSON

1 4 2008

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mg

MD

Gr C

32. Registrar's Signature

TO ASE

29c. License number

020936

THOMAS VOUNTON DR

29d. Date signed (Month, Day, Year)

21702

3/12/08

FREDERICE

Robert Carl Remeikis, Sr

2008 08357

		- For State Certifica	te of De	eath		70	Reg. No.	2001	
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)				2. Date of De	ath		3. Time of Death
gdical Exami		Robert C. Remeikis Sr				Month March 7,	2008	Year	1120 hrs
		4a. Facility Name (if not institution, give street and number)		ity, Town, or		Death		nty of Death	
		152 Teal Circle	0	cean Pine	S		Word	ester	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	_	Under 1 Yea			Birth(MM/DD/Y	YYY) 9. Birtl Foreigr	nplace (State or
Director		212-20-7058   1X M 2 F   81	Yrs. M	lonths Days	Hours	Min. 07-31	-1926		intry) TL
		Usual Residence of Decedent				10.01			
any		10a. State 10b. County 10c. City, Town of	r Location					1.0	10d. Inside City Limits
		Maryland Worchester Ocea	n Pin	es					1 Yes 2 X No
daryland 28a-f show 1 at once.	용	10e. Street and Number		f. Zip Code			10g. Citizen o	f What Coun	try?
th the Maryland 23a or 28a-f sho notified at once.	Director	150 Teel Cimele	1	21811			U.S.A.		
ith th		152 Teal Circle  11. Marital Status 12. Was Decedent Ever in U.S.	13. Was De			n? ( Specify Yes or N			can Indian, Black,
ath w	Funeral	1 Never Married 2 Married Armed Forces?				Puerto Rican, etc.)		Vhite, etc.	
er de		1X Yes 2 No 3 X Widowed 4 Divorced If Yes, Give Year	1 Yes	<sub>2</sub> X No	specify:		Spec	ify: Wh	ite
irs afi ural' ming	ò	l or Dates:				nd of work done	16b. Kind o	of Business/II	ndustry
2 hou "nal	ě	Elementary/Secondary (0-12) College (1-4 or 5+)	luring most o	of working life	. DO NOT u	se retired)			
336 thin 72 ne. than "edical]	휠	4 C1a	assifi	ed			Feder	ral Go	v't
5-0036 led within 7' Tygiene. other than the Medical	Completed	17. Father's Name (First, Middle, Last)			18.Mother's	Name (First, Middle	, Maiden Surn	ame)	
21215-003 uld be filed withi Mental Hygiene, marked other the revent, the Med	æ	Joseph Remeikis			Anna	Bobelis			
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. T's marked other than "natural", or items 23a or 28a-f she matic event, the Medical Ext.miner must be notified at once	2					er or Rural Route N			Zip Code)
y, MD 21215-0036 and 2 should be filed within 7 tealth and Mental Hygiene. tem 27 is marked other than traumatic event, the Medical		Robert C. Remeikis, Jr. (Son) 87	742 Oa	kleigh	Rd P	arkville,	MD 212	234	
Baltimore, ME semit. Pages 1 and 2 s Department of Health a important: If item 27 njury or other traum		20a. Method of Disposition 20b. Place of scompton	f Disposition bry or other p		metery,	Date	20c. Locat	ion - City or	Town, State
JOF ages ages nt of it: If		A bullar 2 Cremation 3 Removal from State	•	,	,	03-10-200	8 Balt	imore,	MD
Baltimore, permit. Pages 1 an Department of He- important: If ite		4 Donation 5 Other Specify: BayV16 21. Signature of Funeral Service Licensee				SCHIMUNE			
Baltimore, ME permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		Storm Mil Dinalog.	1			9705 BEG			10142
Physician		23a. Part I. Inter the disease, or complications that caused the death. Do no	t enter the m	node of dying,	such as ca	rdiac or respiratory	arrest, shock, o	or heart	Approximate Interval
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic Cardiovascul	ar Diseas	e.					Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	ui 2,000						
		Sequentially list conditions, b							
	ner	if any, leading to immediate Due to (or as a consequence of):							
	Examiner	(Disease or injury that initiated							
d d ansit	EX	events resulting in death) Last Due to (or as a consequence or):							
760, cate be executed physician and the burial - transi	Medical	UNPENDED AMENDED							
760, icate be extended the burial	led	IF FEMALE: 23c. If yes, outcome of pregnancy	**			•	23d. Da	te of deliven	,
876 tifica ng ph	m/N	23b. Was decedent pregnant in the past 12 months?	Fetal d	leath 3	Ectopic	pregnancy	Mon	ith [	Day Year
Box 68 death certiff the attending of for use as 1	/sician/	4 Pregnant at time of death 5		(Specify)					
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bat th	by P	Part II. Other significant conditions contributing to death but not resulting	in the unde	rlying cause	given in Par				the cause of death?
F. P.C	b b					2,415,50			
Records,  The law require ficate has been si	ompleted						topsy	prior to d	topsy findings available completion of cause of
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tal Rec ian: The certificate ector, page	e C	25. Was case referred to medical		26.Plac	e of Death (	Check only one)			
Vital Insician: this certi	o B	examiner?  1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	utpatient 3	DDA	Other <sub>4</sub>	Nursing Home 5	Residence	6 Other	r: Scene
of \ ing Phy After th	-	27. Manner of Death 28a. Date of Injury 28b. 1	Time of Injury	y 28c. Inju	ry at Work?	28d. Descrit	e how injury o	ccurred	
ion tendiu eath. tor: A the fur	tion	1 ✓ Natural 5 Pending (Month, Day, Yaar)		1	Yes 2	No			
Division tal or Attendi rs after death.	ica	2 Accident Investigation 28e. Place of Injury - At home, fa	rm, street, fa	actory, office	building, etc			lumber or Ru	ral Route Number, City
Div pital or ours aft	Certification:	3 Suicide 6 Could not be determined (Specify)				or Towr	, State)		
Hospi 4 hou Funer ely fil	Š	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ith occurred	at the time, d	ate and plac	ce, and due to the ca	ause(s) and ma	anner as stat	ed.
Division of Vital Records, P.O. Box 68 <sup>-</sup> To the Hospital or Attending Physician: The law requires that the death certificate but a function of the Function After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	one) 2 Medical Examiner: On the basis of examination and/or in	nvestigation,	in my opinio	n, death occ	curred at the time, da	ite and place, a	and due to th	e cause(s)
To To Con	Mec	and manner stated.  29b. Signature and title of certifier		29c. Licens	se number	CME	29d. Date	signed (Mo	nth, Day, Year)
		TID WING		0.0	M.E.	¥1110	March	8, 2008	
		30. Name and address of person who completed cause of death (Item 23a)							
10			111 Penr	n Street, E	altimpre,	, MD 21201			
	late	31. Date filed (Month, Day, Year)  32. Registrar's Signature							
Regis		21/10 7 / 2000 //20 - //	MagaR						

08-01957 Eugene Rook, III

Please Type or Print in Black Indelible Ink. Ensure A State of Maryland / Department of Health and N Certificate of Death	Reg. No.	2008	5
's Name (First, Middle,Last)	2. Date of Death	3. Time of	

Eugene Rook, III	1-	For State	210 01 111	ui j .uu	Certifi	icate of	Death				Re	g. No.	Bross Tear	
Physician		gistrar Decedent's Name (First, Middl	e,Last)							I M	ate of Death	Day Ye	ear	3. Time of Death
Madical Examine	er	Eugene Clark	Rook,	III							arch 9, 2	008 4c. County	of Deal	
•	4	a. Facility Name (if not institution	n, give street	and number)	<u> </u>		b. City, Tow		cation of I	Death		4c. County	, oi Deat	"
		3240 Foster Avenue					Baltimo		If Under	24Hrs 18	Date of Birt	h/MM/DD/YYY	YY 9. B	rthplace (State or
Funeral	5	Social Security Number	6. Sex	7. Age	e (In yrs. last	birthday)	If Under	Days	Hours	Min.			II-ore	ountry) Germany
Director		226-21-2542	1 X M 2	F	40	Yrs					06/09	/196/_	ئــــــــــــــــــــــــــــــــــــــ	Germany
		Isual Residence of Decedent			10c. City, To	own or Locat	ion							10d. Inside City Limits
v any	1	0a. State 10b. County												1 X Yes 2 No
and sho	ā L	Maryland			Balt	imore	10f. Zip C	ode			1	0g. Citizen of	What Co	untry?
Maryl 28a-l	Director	0e. Street and Number					1	1224			1	USA		
3a or		3240 Foster Av	enue	Vas Decedent	Frontin II C	13 W	as Decedent			n? (Specif	y Yes or No	- 14. Ra		erican Indian, Black,
t be n		Marital Status     Never Married 2 N	A	Armed Forces?	?	If Y	es, specify	Cuban,	Mexican,	Puerto Rica	an, etc.)	[ *v	hite, etc.	
r deal	ᇍ	3 Widowed 4 Di	1 X	Yes Give Year 19	86 <sup>№</sup> 198	38 1	Yes 2	No 2	specify:				y: Wł	
is afte	<b>₽</b>  -	15. Decedent's Education (Sp				En Decede	nt's Usual O nost of work	ccupation	on (Give k	ind of work	done	16b. Kind of	Busines	s/Industry
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5-00 ed wij lygien other	Completed	17. Father's Name (First, Middl	e, Last)					1				Maidell Sulla	iiic)	
218 be fill ntal F	Be	Eugene Clark 1	Rook,	Jr.		LAOh Moilir	ng Address	(Street	Elai	ne Lu	<u>ind in</u> al Route Nu	mber, City or	Fown, St	ate, Zip Code)
21 hould hould Me is ma	P				.1	1700	Sonic	ні	ohway	, #80	)2. Pe	ensacol	a, F	L 32503
MC nd 2 sl alth ar m 27 sum 2	ļ	Eugene Clark 1				lace of Dispo	osition (Nam	e of cer	netery,	, C	ate	20c. Locati	on - City	or Town, State
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland neart of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other tranmatic event, the Medical Examinar must be notified at once		20a. Method of Disposition  1 Burial 2 Cremati	on 3 R	emoval from S	state Fun	ematory or o	ther place)	es c	م ا	02/1	2/2008	Chant	i11s	, Virginia
Page ment or oth		Donation 5 Other	Specify:		Cha	777113	V					Funera		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at ouce.	1	21. atu o uneral vie	\. <u></u>	MC	0060	1 .	120E T	. 11	o Uox	zon R	oad.	Alexand	lria.	VA 22307
		23a. Part I. Enter the disease,	or complication	ons that cause	0968 ed the death.	Do not enter	the mode of	f dying,	such as c	ardiac or re	espiratory a	rrest, shock, o	r heart	Approximate Interval Between Onset and
Physician Tedical	١	failure. List only one cau	se on each in	ic.										Death
aminer		Immediate Cause (Final disea or condition resulting in death	se a. nan Due t	to (or as a con	sequence of	):								
		Sequentially list conditions,	b										_	
	je	if any, leading to immediate cause. Enter Underlying Cau		to (or as a cor	sequence of	):								
	Examine	(Disease or injury that initiated	, ··-	to (or as a cor	nsequence of	·):								
d ted	EX	events resulting in death) Las	d.											
execu	ical	UNPENDED	_ AN	MENDED										
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funerate or After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	IF FEMALE:	2:	3c. If yes, outo	come of pregr	nancy						23d. Da	ate of del	livery Day Year
387 rtifica ling pl	au/	23b. Was decedent pregnant i past 12 months?	1 '	Live birth	at time of de		Fetal death		Ectop	ic pregnan	су	IVIO	101	50,
Box 687  e death certific  the attending F  ed for use as the	sician	1 Yes 2 No 9	Unknown g			eath 5	Other (Spe	Giry)						
. B.c. he de y the shed for the def	Phy	Part II. Other significant cor				esulting in th	ne underlyin	cause	given in F	Part I.				te to the cause of death?
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Orc aw re as be 2 sho	흹										pe	erformed?		ath? ✓ Yes 2 No
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tal certif	Be	25. Was case referred to me examiner?		oital:	atient 2	ER/Outpat	ient 3	DOA	Other;		Home 5	Residence	6 🗸	Other: Scene
f Vi Physic r this	2	1 Yes 2 No 27. Manner of Death		28a Date of	Injury	28b. Time		28c. In	jury at Wo	ork?	28d. Descri	be how injury	occurred	
n of ding l	ü	A District	Pending	FOUND: D	ay,Year)	FOUND:		1	Yes 2	No	-	anged self		
Siol Attended to death	iati	Mar 9, 2008 1712 hrs  2 Accident Nestigation Investigation   Mar 9, 2008   1712 hrs  28e. Place of Injury - At home, farm, street, factory, office building, etc.   28f. Location (Street and Nur								Number	or Rural Route Number, City			
Division of Vital Records, tal or Attending Physician: The law requirent stander death.  The pirector: After this certificate has been simel in by the funeral director, page 2 should the	1	1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 1 Single Family 1 Single Family 1 Pending Investigation 3 Suicide 6 Could not be determined 1 Single Family 1 Single Fam									e, MD			
Cospits hours unera	၂ ပီ	4 Homicide  29a. Certifier 1 Certifyir	o Physician:			death o	occurred at the	ne time,	date and	place, and	due to the	cause(s) and r	nanner a	s stated.
the H the Fi	ica	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier												
To 1	Med	29b. Signature and title of ce		iu manner sta			2		nse numb	ег				(Month, Day, Year)
	-	Com n		1. 1	CII.			0.0	C.M.E.			March	10, 2	UU8
		30. Name and address of pe	rson who cor	npleted cause	of death (Ite	m 23a)								
10		Donna M. Vincenti		ssistant Me	edical Exa	aminer	111 Penr	Stre	et, Balti	more, M	21201 טו 			
	Stat	31. Date filed (Month, Day, Y	()	32 Reg	istrar's Signa	ire .	me							
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			For State Registrer	State of	Marylan	_	artment of I		Mental Hy	giene) Reg. No.	008	0835	9	
	Physici	20	1. Decedent's Name (First, Middle, Last)						2. Date of De	ath Day	Year	3. Time of Deat	_	
5.5	/Medic	al	ORIE KATHE			CICHARD		and another of Dan	Man	ch 12	2008 inty of Death	(000)		
	Examin	er	4a. Facility Name (If not institution, give s  LOCH RAVEN CENTER		oer)		Balti	or Location of Dea	ın		•	County		
3	Funeral		5. Social Security Number 6. Sex	7	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs				lace (State or Forestry)	eign	
2	Director		216-01-0189	M 2∑F	90	Yrs.	Months Days	Hours Will	Aug 30		Mary			
3_	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Lin	nits	
2	filed within 72 hours after death with the Maryland Hygiene. the rhen "neturel", or Iteme 23s or 28s-f show ent, the Medical Examinar must be notified at	irector	Maryland Baltimore County Baltimore								1 □ Yes 2 🔀	No		
ir Rendurch			10e. Street and Number								Citizen of What Country?			
01		rai C	8720 Emge Road				21234				USA			
-		une	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Marned 1 Yes 2 No			.S. 13.	<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> </ol>				14. Race - American Indian, Black, White, etc.			
036		by F	3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dates:				1 ☐ Yes 2 💆 No Specify:			Spe	Specify: White			
5-0		Completed by Funeral Director	15. Decedent's Education 16a. [ (Specify only highest grade completed)				Decedent's Usual Occupation 16b Give kind of work done during most of working life. DO NOT use retired)				. Kind of Business/Industry			
2121			Elementary/Secondary (0-12) College (1-4or 5+)				Olife. DO NOT use retired)  Omemaker			Own	Own Residence			
d 2	Hygie Hygie other		17. Father's Name (First, Middle, Last)			Home	maker	18. Mother's Na	ame (First, Middle					
<u>lan</u>	uld be Vental rrked tilc ev	To Be	John Wentz Flossie May Bortner											
Maryland	2 sho and h is ma	·	19a. Informant's Name/Relationship (Ty)						Rural Route Numb		wn, State, Zip	Code)		
e,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "any injury or other traumatic event, the Mespace.		Alberta H. Fischer	(Daug	hter)	lace of Dispo	sition (Name of		rside, C		03 on - City or To	own. State		
Baltimore,			1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from S	State	emetery, crei	natory`or other pla		18/ 2008		-		.	
i i			21 Signature Funeral Servi Alich se	ewsn	PIO	22	Name and Addr	ess of Facility				.iiisy ivaii.	La	
ä	Dermi Deperiment Impo		Martin D. Law	son		6	ITCHELL- 500 York	WIEDEFEL Road B	D FUNERA altimore	L HOME Marv	, INC. land 2	1212		
			Martin D. Lawson  MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of bying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death Onset and Death											
	Physician		Immediate Cause (Final disease or condition resulting in death)		بلا	2011	2 1	2 moi	力石			Origot and Doati		
	/Medical Examiner		1030iting in assum	Due to (d	or as a conseq	uence of):								
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (c	or as a conseq	uence of):								
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√, ,	oe exe cien ar urial-t		resulting in death) Last	Due to (d	or as a conseq	uence of):								
Box 68760	physicate by sine by the b	dicai		l										
ox 6	leath certifica attending ph	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outc			_ + 07.50000			23d.	Date of delive	ery		
	death	in the past 12 months?  1 □ Yes 2 □ No  1 □ Yes 2 □ No								Month	Day Year	i		
SO THE HELE STANDARD TO THE HELE STANDARD THE STANDARD THE HELE STANDARD THE HELE STANDARD THE HELE STANDARD THE HELE STANDARD THE HELE STANDARD THE HELE STANDARD THE HELE ST								underhing acuse group in Flort I 220 Died toh			and use enoteinute to the cause of death?			
	Physician: The law requires that the death certificate be execuled tribic certificete hes been signed by the attending physicien and ral director, page 2 should be detached for use as the burial-transit	þ	Partil. Other significant conditions cor	ithouting to de	atti Dut not res	but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Wunknown				
000	s beer s shou	ompleted		24a					Was an 24b. Were autopsy findings available					
The law by the law by									perfe	opsy prior to completion of cause of death?  2 X No 1 Yes 2 No				
1   Yes										one)				
C 2 2 2 5 1 KNatural 5 Pending (Month, Day Year) Injury Work?										☐ Residence 6 ☐ Other (Specify) escribe how injury occurred				
									now injury ou	njury coodcd				
Solucide    Solucide   Could not be determined   28e. Place of Injury At home, farm, street, factory, office   28f. Location (Street and Number building, etc. (Specify)   City or Town, State)										ımber or Rura	al Route Number.			
4 6 8 9 O														
	Hoep 24 hou Fune stely fil	edical	29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  and manner stated.											
# .c. # de										29d. Date signed (Month, Day, Year)				
	->-0		Mu Att.	gudin	Sph	Sierc	n D	5364	12	Han	4 6	2200	8	
	1		30. Name and address of person who co	mpleted cause	of death (her	n 23a) (Type,	Print)	. 0 =	1127	DA	Mas	- 2/7	00	
_	(		31. Date filed (Month, Day, Year)	39 R	gistrar's Signa	V. C	nans	5 5/	4602	Del	1/11/02			
	Sta Registi		WAR 1 4 2008	100	1	130	de							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🦾 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month March 9, Morgan Thomas Reedy /Medical 2008 3:05 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sev 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□F Director 230-12-6060 Oct. 9, 1923 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 805 Moores Mill Road by Funeral 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 21215-0036 1 ☐ Yes 2√2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 is marked other the any Injury or other traumatic event, the once. Electronic Technician U.S. Government Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Franklin Reedy Phoebe Jane Waddell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reva Reedy / Wife 805 Moores Mill Road, Bel Air, MD 21014 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Hilltop Service Corp 3-13-08 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. 23a. Part1. Enfeythe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of the art failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner NEWMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off and requires that the death certificate be executed HEART Due to (or as a consequence of): 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: Certification: To 1 opatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Iniury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 03-09-2008

State Registrar 31. Date filed (Month, Day, Year)

MAR 14

Ede

#

32. Registrar's Signature

107

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Claudia Kroker M.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-01913 State of Maryland / Department of Health and Mental Hygiene

Amend Item 5 per fh, g8/3 in the 109/08dhb Lance Montgomery Reese 2008 0836 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day March 7, 2008 1859 hrs LANCE M. REESE, **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Carroll Westminster Carroll Hospital Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** Months Days Hours Min. Director 11/01/1971 Country) MD 218-86-5986 1 X M 2 F 36 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State Yes 2 X No PA **ADAMS** NEW OXFORD 28a-f shov Examiner must be notified at once. death with the Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 17350 USA 60 RED HILL RD. 這 23a 14. Race - American Indian, Black. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces' 1 Never Married 2 Married 2X No Yes Yes 2 X No specify: Specify: WHITE 4 X Divorced If Yes, Give Year within 72 hours after 3 Widowed þ 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Baltimore, MD 21215-0036 PLUMBER CONSTRUCTION 10 Pages 1 and 2 should be filed withintent of Health and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ent of Health and Mental Hy int: If item 27 is marked o WILLIAM DOC REESE BRENDA SHIPLEY æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 2 BRENDA REESE MOTHER 60 RED HILL RD., NEW OXFORD, PA 17350 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 3/11/08 tant: or oth Uniontown, MD Donation 5 Other Specify UNIONTOWN LUTHERAN ФЕМ 22. Name and Address of Facility 21. Signature of Funeral Service Lic FLETCHER FUNERAL HOME, 254 E. MAIN ST., WESTMINSTER, Approximate Interval 23a. Part I. Ent of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Methadone Intoxication Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Couse (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED 23a, 27, 28a-f per ME g877 3/25/08 amh physician a the burial -X UNPENDED The law requires that the death certificate be Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy IE EEMALE Year 23b. Was decedent pregnant in the Month Day Live birth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. þ 1 Yes 2 No 3 Probably 4 V Unknown Completed of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? 1 🗸 Yes 2 No ✓ Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical æ Other<sub>4</sub> examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this 1 V Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? After 27, Manner of Death Certification: Natural 1 Yes 2 X No Division 5 Pending death. Inknown Found 3/7/08 found 6:20pm Accident Investigation 2 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. hours after 3 6 X Could not be or Town, State) 202 estminster MD Suicide Wimert Ave. determined within 24 hours a To the Funeral I (Specify) Single family residence the Hospital Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie March 8, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD 31. Date filed (Month, Day, Year) kegistrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per ft 9877 3-21-08 yt State of Maryland? Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** maran Harry L. Rainier, Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1.00 M 2□ F Director 219-44-5 January 26, Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d Inside City Limits 10a State 10b County od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 1 No Director MD Harford *Forest Hill* 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 1413 Kahoe Rd. 21050 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Item any injury or other traumatic event. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ② No Specify: þ 3 Widowed 4 Divorced White Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Steel Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Priscilla Carver Harry L. Rainier, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine J. Rainier Forest Hill. MD.(wife) 1413 Kahoe Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 03/17/2008 Towson, N 22. Name and Address of Facility Duda Ruck Funeral Home 4 □ Donation 5 □ Other (Specify) of Dundalk 21. Signature of Funeral Service Licensee Inc.7922 Wise Ave. Dundalk, MD 21222 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Englocarditis Physician month /Medical Due to (or as a consequence of): 1 month Examiner Backerema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed the burial-transit attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 □ Ectopic pregnancy 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown the Hospital or Attending Physician: The law requires that the thin 24 hours after death.
 the Funeral Director: After this certificate has been signed by 1 mpletely filled in by the funeral director, page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 Tyes 2 ER/Outpatient 3□ DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending M 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Jaus AT 2438946 Marin

DHMH 17 Rev 1/2001

State

Registrar

Baltimore MD

University PKWU

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Bina vora Tairi

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31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene	. 6
otate of Marytana / Department of Health and Mental Hygieng	. 4

For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 10:10 AM Carl B. Shirley Jr. **Physician** March 10, 2008 ar /Medical 4a. Facility Name (If not institution, give street and number)
Charlotte Hall Veterans Home 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Marys Charlotte Hall If Under 1 Year | If Under 24 Hrs. | 8 Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 MD untry) **Funeral** Days Months Hours 578-34-4705 158 M 2 ☐ F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If item 27 ie marked other than "netural", or items 23s or 28s-1 ehow 10b. County 10c. City, Town or Location 10d. Inside City Limits if item 27 ie marked other than "netural", or items 23a or 28a-f ehov or other traumatic event, the Medical Examinar must so rediffied at Saint Marvs Charlotte Hall 1 ☐ Yes 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 29449 Charlotte Hall Rd. 20622-United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 XYes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 1946 - 52 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
Construction (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Carl B. Shirley Sr. Francis Elizabeth Clemmer ၉ 19a. Informant's Name/Relationship (Type, Print)
Conrad J. Shirley/Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1125 Rawlings Ct. Prince Frederick, MD 20678-20b. Place of Disposition (Name of cemetery, crematory or other place)
Uniformed Services 20a. Method of Disposition 20c. Location - City or Town, State Mår 11 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Bethesda, Maryland injury 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22RapparfdderalFacilicremation Services M00382 any ir 933 Gist Ave. Silver Spring, Maryland 20910uplind Loker 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HOVANC & disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit led by the ettending physicien and detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours effer death.
To the Funerel Director: After this certifics funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Alatural 5 Pending investigation 1 ☐ Yes 2 ☒ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOL +1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNAPOLIS NAZNIN MEDICAL 2001 31. Date filed (Month, Day, Year) 32. Refistrar's Signature. State MAR 14

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Month Silvistri eseph 1:34 PM 2008 march /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Cromwell (Temes 1) Balhrere 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 12 M 2□ F Days Hours 64 Director 218.42.7342 02.11.1944 MD Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes > No Director MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8710 Emge Road 21286 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 → No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: White 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer unk Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Be Augusto Silvestri Anna Concordia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gareth Gastley/Friend 3476 Messersmith Road, York, PA 17408 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 03.13.07 Beltsville, MD 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, P. 21. Signature of Funeral Service Licensee A. 8717 Green Pastures Dr. Balto., Die Rille 23a. Part1. Enfur the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CAD years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner hemy ASUVO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-trans requires that the death certificate be exec Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 4 Pregnant at time of death signed by the a ☐Yes 2☐No 9 Unknown 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Cinemi 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 115 1∐ Yes 2 1No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Weng Rly D31295 3/1360 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 M Cherry St Suto 4002 Tousom KLIPSZ 31. Date filed (Month, Day, Year) 32 Registrar's Signature Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month MARCH 11, 2008 RAYMOND DANIEL SMITH 5:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
June 20, 1926 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 1 M 2 □ F 81 220-18-0970 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director Maryland Frederick 1 ☐ Yes 2K No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8945 Walter Martz Road 21702 Funeral United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. White þ Specify: 3 Widowed 4 Divorced "natura!", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event, the once. 12 Machinist Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Daniel Smith, Sr. Mildred Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Smith / Son 9404 Boulder Rd. Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 13, 1 ☐ Burial 2 Excremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Resthaven Crematory 2008 |Frederick, Maryland 21. Signature of Funeral Service Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part1. Enter the disease, or comp shock, or heart failure. List only Approximate Interval Between Opset and Death cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest the cause on each line. Immediate Cause (Final disease or condition resulting in death) therascleratic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed ician and burlal-tran Due to (or as a consequence of): Physician/Medical law requires that the death certificate the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 ☐ Ectopic pregnancy jo in the past 12 months? 4□Pregnant at time of death Month Day Year 5 Other (specify) ed by the a detached f 1 Yes 2 No Ö 9 Unknown ٦ s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, <u>}</u> Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No autopsy page ( certificate 1∐ Yes Physician: 25. Was case referred to medical examiner?
1 Yes 2 No Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 □ DOA this 28a. Date of Injury (Month, Day funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day,

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Year,

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To the

and manner stated.

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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	2 8 m	- 4	Registrar  1. Decedent's Name (First, Middle, Li	ast)			Dealli	2. Date of	Reg. No	o.C. U U U	3. Time of Death
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	/Medic Examin		4a. Facility Name (If not institution, gi		<u> </u>	4b. City, Town	, or Location o		- '	c. County of Death	
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	Funeral Director		218-58-6198	Sex 7. Aga 1 🔀 M 2 🗆 F	e (In yrs. last birth)	Months Day		Min. 8. Date of (Month, May			place (State or Foreign ntry) ~vland
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location					10d. Inside City Limits
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	r 28a-	Funeral Director	10e. Street and Number			10f. Zip Code	e		10g. C	itizen of What Cou	ntry?
	th witt 23a o ist be	al D	2250 Fawn Haven	Court		217	784			U.S.A.	
	r dea	uner	11. Marital Status	12. Was Decedent I Armed Forces?		13. Was Decedent o	f Hispanic Oriç uban, Mexican	gin? (Specify Yes or , Puerto Rican, etc.)	No-	14. Race - Americ Black, White,	
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fi	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ X N If Yes, Give Year or Dates:	No	1 □ Yes 2 🙀 N					hite
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λγ Jre.	es 1 a of Her		20a. Method of Disposition		20b. Place of D	isposition (Name of crematory or other p		Date		ocation - City or T	
William altimore.	Pages ment of I ant: If ite ury or o		1 ⊠ Burial 2 □ Cremation 3 [ 4 □ Donation 5 □ Other (Spec			ood Cemet	i i	March 14.	2008	Baltimo	re. MD
Balt ⊱	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marken any Injury or other traumatic once.		21. Signature of Funeral Service Lice	ensee		22. Name and Add	dress of Facility	Baltimor	e, Ma	ryland 2	21214
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			23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	market .	<i>a</i>			cardiac or respirator	y arrest,		Approximate Interval Between Onset and Death
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Box	death certifica attending pl	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	pf pregnancy					23d. Date of deliv	ery
		Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1⊟Live birth 4⊟Pregnant at 9⊟Unknown	2 ☐ Fetal death time of death	3 ☐ Ectopic pregna 5 ☐ Other (specify)			_	Month	Day Year
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Division or Vital Records, P.O	The law requires that the death certif ate has been signed by the attending bage 2 should be detached for use as	by	Part II. Other significant conditions	contributing to death bu	ut not resulting in tr	e underlying cause	given in Part I.			/	the cause of death? bably 4 □Unknown
S	w requir been si should	lete							as an	24b. Were auto	opsy findings available
Be	<b>sician:</b> The law certificate has t irector, page 2 s	Completed						—— ai	utopsy erformed? s 2 N	prior to co	impletion of cause of
ta		BeC	25. Was case referred to medical				26. Place	of Death (Check on		o ILITES	2140
>	Physician: r this certifice ral director, p	TO E	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	nt 2 ☐ ER/Outpa	itient 3 DOA	other: 4 ☐ Nur	rsing Home 5 🗆 R	esidence	6 □Other (Speci	fy)
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Σi	after after Dire	Certification:	4 ☐ Homicide determined		(Specify)	, street, factory, offic		City or 154 Z	Town, Stai	and Number or Run te) CM Poac	I riodie ramber,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director; After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying P	hysician: To the best of	of my knowledge, d	eath occurred at the	time, date and	d place, and due to	the cause(	s) and manner as s	stated.
	the Hin 24 the Fi	ledical	one)	miner: On the basis of and manner sta	ted.			un occurred at the tir	1		
	with Con	Σ	29b. Signature and title of certifier			29c. Lice	nse number	U.S	29d. Da	ate signed (Month,	
			held	stubs_			1116	70		3/10/2005	8
	12		30. Name and address of person who	completed cause of de			+ Ral	itmore,	MD	21201	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	No Spec	1 1200	1,11.01			
	Registr	ar	MAR 1 4 2008	JARKELIA 1	C. Carried	Part .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 13, 2008 Year Physician 5:15 Shuford Ам Mildred M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Hamilton Genesis Nursing Home Baltimore 8. Date of Birth (Month, Day, Year) June 13, 1920 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2XXF 87 Hours Maryland 219-10-9128 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director MD N/A Baltimore 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 6040 Harford Rd. 21214 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ŽŽNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc thould be filed within 72 hours after of Mental Hygiene.

marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XX No Specify. <u>Ş</u> 3€Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fill h and Mental H is marked oth Be Robert Glass Anna Bosnan 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important; If item 27 is rr any injury or other traum 6205 Greenmeadow Way Baltimore, MD 21209 Ms. Michele Loewenthal / Quardian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Moreland Memorial Park 03/17/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Kimberly Davidson 22. Name and Address of Facility 5305 Harford Rd Balto., MD 21214 Leonard J. Ruck, Inc. MIVO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ALIHEIMER 19 DISEKSE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 ☐ Ectopic pregnancy Month Year 4☐Pregnant at time of death 9☐Unknown Day 5 Other (specify) signed by the at d be detached for 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>\$</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After the completely filled in by the funera 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🗹 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D16619 March 13, 2008 30. Name and a daress of person who completed cause of death (Item 23a) (Type, Print) RD. BALTIMORE. C.VERGARA- SOARES 6040 HARFORD MD. 21214 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 14 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Helen M. Sohn 1330 March 10 2008 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner altimore If Under 1 Year | If Under 24 Hrs. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Social Security Number 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 💢 F 220-07-8620 Director 88 10-05-1919 Maryland Usual Residence of Decedent permit. Fages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiene. Important: if Item 27 is marked other than "--- any injury or other-than". 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Maryland Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3513 E. Northern Pkwy Apt C-3 U.S.A.

14. Race - American Indian, by Funeral 21206 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) House Wife <u>Own Home</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James J. Fuka Marie Shanta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Sheaff (Daughter) Beveret Branch Lane Rabun Gap, Georgia 30568 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □Removal from State Parkwood Cemetery 4 Donation 5 Dother (Specify) 03-14-2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Decen ( 9705 Belair Rd Baltimore, MD 21236 10 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ocardia roba /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown sate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No 2 After this 28a. Date of Injury (Month, Day Year) 27. Manner eath 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 u atural I Director; A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Division or Vital Records, P.O. Box 68760. To the Funeral 24

> State Registrar

31. Date filed (Month, Day, Year) WAR 1 4 2008

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Typa, Print)

Terrance L. Baker Good Sana-itan Hospital Bultimore

31. Date filed (Month, Day, Year)

32. Registrar's Signature

29c. License number 00058570

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08369 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Catherine J. Smith $1022~A^{M}$ 03-11-2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 305 Northway Drive Havre de Grace Harford If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 05-08-1031 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Days 1 □ M 2 🔽 F Maryland 76 212-28-9251 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d Inside City Limits 1 ☐ Yes 2X No Maryland | Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 Northway Drive 21078 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles E. Adkins Jr Ernestine V. Breyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank B. Smith Jr. 305 Northway Dr. Havre de Grace MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □Removal from State Trinity Ep. Cemetery 4 □ Donation 5 □ Other (Specify) 03-15-2008 Churchville, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Lichs Schimunek Funeral Home of BelAir Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pancreatic Cuncer 16 months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Day Year 4□Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death?

Physician /Medical **Examiner** 

death certificate be executed

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending

hours after death.

within 2

**Physician** 

/Medical

Examiner

Director

Funeral

ģ

Completed

Be

**Funeral** 

Director

show.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 shov any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

with the Maryland

sician and attending physician for use as the buria þ page 2 certificate l this After thi funeral thin 24 hours after deam.

o the Funeral Director A

Examine Physician/Medical þ Completed 25. Was case referred to medical Be 은 27. Manner of Death Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown

examiner?

Natural

2 Accident

3 Suicide

29a, Certifier

4 ☐ Homicide

(Check only one)

1 ☐ Yes 2 No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

28a. Date of Injury (Month, Day Year)

1 ☐ Yes 🔑 No autopsy performed

3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier seeslief

5 ☐ Pending investigation

6 Could not be determined

29c. License number DOWY2050

29d. Date signed (Month, Day, Year) 12/00

Registrar

31. Date filed (Month, Day, Year) MAR 1 4 2008



Injury

			1 - State of Man		artment of I rtificate of		nd Ment	, ,	ne No200	8 (	083	370
1	Physici /Medi		1. Decedent's Name (First, Middle, Last)  Joanne Smith				Me	ite of Death onth		Year	3. Time of 1:37	Death pM
	Examir		4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital		4b. City, Town, Clir		Death		4c. County o		eorge'	's
	Funeral Director		163–34–1288 ¹□ M 25xF	In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days			te of Birth onth Day Yo 04/19	944	9. Birthpla Countr	ce (State or y) PA	Foreign
	Aaryland f show ed at	ō	Usual Residence of Decedent   10a. State   10b. County   Prince George's   10b. County   10b. Coun	Oc. City, Town or Lo		ıitland	<b>3</b>			100	d. Inside Cit	
	with the Na or 28a-	I Direct	10e. Street and Number 2210 Lakewood Street		10f. Zip Code	20746		10g.	Citizen of WI		y?	
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ted by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced  15. Decedent's Education	16a. Deced	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No dent's Usual Occu	Specify:				- Americar White, et Blac	c. Ck	
21215	d within 72 giene. r than "n the Medi	Completed by	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+) 3	life [	kind of work done DO NOT use retire Homemake	ed)	of working		Ow	m Hoi	me	
land	2 should be filed and Mental Hygi is marked other aumatic event, tl	To Be C	17. Father's Name (First, Middle, Last) William Purifoy				s Name <i>(First</i> Sa <b>ra</b> h	, Middle, Mai Weems	den Surname	)		
Mar	nd 2 should alth and Men 27 is marke r traumatic		19a. Informant's Name/Relationship (Type. Print)  Arron Smith / Son	I	ng Address (Street						Code)	
altimore,	Pages 1 and 2 nent of Health i nt: If item 27 liny or other tra		20a. Method of Disposition  1 □ ② □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)	20b. Place of Disposemetery, cremetery, cremetery	natory or other pla	cy C	Date 03/14/2	- 1	e. Location - C Pittsb			
Balti	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licensee  Dougla V- Marchal	22	Name and Addres Charles 1501 Eas	ess of Facility L. Ste	evens F	uneral	. Home	Inc.	21230	)
8760,	Physician but and but sician and but sician and but sician and street but sician site but all fluorities and but sician site but all fluorities and but sician site but all fluorities and but sician site but sician sician sician sician sician sician sician sician sician sician sician sician sician sici	al Examiner	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last  Due to (or as a condition or injury that initiated events resulting in death) Last	consequence of):	er the mode of dyi	ing, such as c	ardiac or resp	iratory arrest			Approximate nterval Betw Onset and D	/een eath
O. Box 6	ath certif titending or use as	Physician/Medical	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  d.  23c. If yes, outcome pf the past 12 months? 1  Pregnant at time 12  Pregnant at time 13  Pregnant at time 14  Pregnant at time 15	☐ Fetal death 3 ☐	Ectopic pregnanc	у			23d. Date Mont			'ear
ds, P	uires that the de signed by the a Id be detached I		Part II. Other significant conditions contributing to death but n	not resulting in the un		ven in Part I.	23		co use contrib	oute to the		eath? Inknown
I Kecords,		Completed by	DIABETES MELLIT	US			_	fa. Was an autopsy performed 2 1	d? pri	or to comp ath?	sy findings a pletion of ca	vailable use of
Vital	ysician: Th s certificate director, pag	To Be (	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 patient	2 ☐ ER/Outpatien	t 3 DOA Oth	ner:	of Death (Chec		e 6 □Other	(Spacify)		
DIVISION OF	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	Certification: T	27. Manner of Death  1 Natural 5 Pending (Month, Day Young) 2 Accident Investigation	28b. Time of Injury	28c. Inju Wo M 1		28d. D		injury occurred			
Ž	ital or At urs after d ral Direct lled in by	Certifi	4 Homicide determined 200: Place of Injury building, etc. (5	- At home, farm, stre Specify)			Ci	ty or Town, S	ŕ			)e <i>r</i> ,
	he Hosp in 24 hou he Fune pletely fi	Medical	29a. Certifier (Check only one)  1  Certifying Physician: To the best of m 2  Medical Examiner: On the basis of ex and manner stated	camination and/or inv	occurred at the ti	ime, date and opinion, death	place, and du n occurred at t	e to the caus he time, date	se(s) and man and place, ar	ner as stat nd due to t	ted. he cause(s)	i
)	To T Com	Σ	29b. Signature and title of dertifier		29c. Licens	5290	00		Date signed 8		ay, Year)	1
			30. Name and address of person who completed cause of death MUSA MOMOH MD 870	O CENTR	AL AV.	#30	ol, LA		WER	MO	2078	?5
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's MAR 1 4 2008	Signature	Speeds?							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fb 23 ptTTper me 9878 4-2-08 vt.

State of Maryland Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2008 **Physician** 23:50 March 6, Mary Ellen Scott /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year June 2, 19 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Social Security A **Funeral** Days Hours Min 1 □ M 2 🔀 F Yrs. 94 1913 Illinois Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10b. County Examiner must be notified at 1 ☐Yes 2X No Director Maryland | Montgomery Potomac · 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 20854 United States 11215 Seven Locks Road, #203 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White Specify. ≥ 3 Nidowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Kirkpatrick Gustav Radebaugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10904 Riverwood Drive, Potomac, Maryland 20854 Patricia Holloway / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March Tate 3 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Bethesda, Maryland 2008 Montgomery Crematorium, Inc. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M00896 7557 Wisconsin Ave., Bethesda, MD 20814-3501 23a. Part1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arresponds, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** bractu /Medical Due to (or as a consequence of) Renal **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine N Wemonia Due to (or as a consequence of): Box 68760 be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, fracture left humerus 1 Tyes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 X No or Vital 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospital: 1 Malinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 X Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d Describe how injury occurred subject fell 27. Manner of Death 28c. Injury at Certification: C ⊗ Division 1 Natural 5 Pending investigation 09:00 Jan. 28, 2008 1 ☐ Yes 2 No at Assisted Living Facility Hospital or Attendi 24 hours after death. Funeral Director; A 2 X Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Summerville Assisted Living 11215 Seven Locks Rd., Potomac, MD To the Hospital of within 24 hours at To the Funeral D 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only onel and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) V006 1302 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Atul Rohate, M.D., 9901 Medical Center Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 4 2008

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Registrar

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			1 - State Registrar	State of Ma	aryland		artment of F <i>rtificate of I</i>			ental Hy	giene Reg. No	7111	8	0837	2
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	Examir	er	4a. Facility Name (If not institution, given Manor Care - I				4b. City, Town, or Potomac		of Death			o. County of Montg		CV	
0.	Funeral	4	5. Social Security Number 6. S		e (In yrs. las	st birthday)	If Under 1 Year	If Under		8. Date of Bi	rth		9. Birthp	lace (State or Foreig	gn
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	r 28a	Director	Maryland Montgon  10e. Street and Number	iery	Poton	liac	10f. Zip Code				10g. Ci	itizen of Wh	nat Cour	itry?	
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	er dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Or an, Mexica	igin? (Spec n, Puerto F	cify Yes or Na Rican, etc.)	0-	14. Race - Black,	- Americ White,		
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21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must <u>be notified at</u>	ted	15. Decedent's Ed (Specify only highest gra	lucation	- 1	16a. Deced	lent's Usual Occup	ation			16b. K	(ind of <b>B</b> usi			
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and	d be f ental k ced of	o Be	Harold Mainze						ssie	Mae		Monto			
Maryland	shoul ind Ma inari imari	T	19a. Informant's Name/Relationship (			19b. Mailin	g Address (Street							Code)	
Ž,	and 2 salth s n 27 ls		Eleanor B. Schro	n / Daugh	ter	11713	Split T	ree (	Circle	e, Pot	omac	, Mar	y1aı	ıd 20854	
Baltimore,	ges 1 t of He If iten or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Plac	ce of Dispon netery, cren	sition (Name of natory or other plac	e)	Da	ate	20c. L	ocation - C	ity or To	wn, State	
ţ	t. Pag tmen rtant: njury		4 ☐ Donation 5 ☐ Other (Specification )	()	Monmo		norial Park		arch 13					, New Jerse	
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	isee	M0119	Ro 3 30	bert A. 0 West Mo	ss of Facil Pumph ntgon	rey F hery A	unera. ve, Ro	l Ho	me/Ro ille,	ckvi MD	lle, Inc. 20850	,
В			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused one cause on each lir	I the death. ne.	Do not ente	er the mode of dyin	g, such as	cardiac or	respiratory a	arrest,			Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Heart										Sudden	
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7	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as											
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Вох	leath certif attending for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			Ectopic pregnancy	,				23d. Date		•	
P.O. E	The law requires that the death cert ate has been signed by the attending age 2 should be detached for use a	Physician/M	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	4□Pregnant at 9□Unknown	time of dea		Other (specify)					Mont	n	Day Year	
	w requires that the de been signed by the s should be detached		Part II. Other significant conditions of	ontributing to death bu	ut not resulti	ng in the un	derlying cause give	en in Part		23e. Did	tobacco	use contrib	ute to th	ne cause of death?	
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0	g Phys er this eral dir	- To	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date of Injur	nt 2 EF	8b. Time of	28c. Injur	4 AJ N		e 5□Res Bd. Describe				1)	
ion	Attending in death.  ector: After by the funer.	atio	1 Natural 5 Pending 2 Accident investigation		/ rear)	Injury		<br Yes 2 □	No						
Division or Vital Records,	or Attendatter death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injubuilding, etc		e, farm, stre	eet, factory, office		28	Bf. Location ( City or To	Street al	nd Number e)	or Rura	l Route Number,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 X Certifying Ph	ysician: To the best of	of my knowle	edge, death	occurred at the tir	ne, date a	nd place, a	nd due to the	causels	s) and man	ner as s	tated.	
	he Ho in 24 h he Fui pletely	Medical	(Check only 2 Medical Exan	niner: On the basis of and manner sta	examination	n and/or inv	estigation, in my o	pinion, de	ath occurre	d at the time	, date an	nd place, an	nd due to	the cause(s)	
	To the within 2	Σ	29b. Signature and title of certifier	1	111		29c. License	e number			29d. Da	ate signed (	Month,	Day, Year)	
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	12		30. Name and address of person who		,		<sup>Print)</sup> n Avenue,	#30	. Ret	theeds	. Ma	rv1an	d 20	1817	
	Sta	te	Loreto S. Albiol, 31. Date filed (Month, Day, Year)	32. Registra			Avenue,	71 JU.	ט אנו פּיִנ	Lucoud	, rid	т у тап	.u	7017	
	Registr	ar	MAR 1 4 2008	Beer as	15	6004									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2008 3:15  $P^{M}$ George Seidman March 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hebrew Home Rockville Montgomery 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1 X M 2 □ F 83 123-14-5038 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ä 28a-f sh notified 1 ☐ Yes 2 X No Director Maryland | Montgomery Rockville the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or 7 1799 East Jefferson St. 20852 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian 'natural', or items dical Examiner ma 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry traumatic event, the Medical tal Hygiene. College (1-4or 5+) Electronics Elementary/Secondary (0-12) Owner Company 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) n and Mental F Be 1 and 2 should be Louis Seidman Bessie Servetnick ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Department of Health Important: If item 27 any injury or other troonce. Laurence Seidman (Son) 7211 Gentian Court, Springfield, VA 22152 20b. Place of Disposition (Name of Temp1e, sematory a ather place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery 5 ☐ Other (Specify) 3/9/08 Cheektowaga, New York 4 □ Donation 21. Signature of Funeral Service Licen 22. Name and Address of Facility Jefferson Funeral Chapel 5755 Castlewellan Drive, Alexandria, VA 22315 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-tran Due to (or as a consequence of) P.O. Box 68760 physician Physician/Medical use as t attending IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant/conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 12 No 3 Probably 4 Unknown 1 ☐ Yes Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an certificate 1□ Yes Division or Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 | Yes 2 | 1√0 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 24 hours after death e Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by determined 4 Homicide 29a. Certifie 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2. 29d. Date signed (Month, Day, Year)

March 06, 2008 29b. Signature and title of certifier win ulu 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 2085 M.D. GIZI MONTROSE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 4 2008

Registrar

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	•	_ FOr	Certificate of Death		g. No. 2008	083/4
Physicia	an	1. Decedent's Name (First, Middle, Last)		Date of Death     Month	n Day Year	3. Time of Death
/Medic		Edmund Francis Shanahan Jr.	4b. City, Town, or Location of Death	MARCH	11 2008 4c. County of Deat	
Examin	er	4a. Facility Name (If not institution, give street and number)  SINAL HOSPITAL UF BALTIMORE	BALTIMORE C	ITY	4c. County of Deat	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		8. Date of Birth	Year) 9. Birt	hplace (State or Foreign untry)
Director		162-26-7817 /5	rs. Monard Says Hours	Jan. 12	, 1933 Per	
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filed within 72 hours after death with the Maryland filed within 72 hours after death with than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notified at	ctor	Maryland Harford Bel A	ir			1 □ Yes 2 XNo
vith th	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?
eath v ns 23a must	Funeral	319 East Belcrest Road  11. Marital Status 12. Was Decedent Ever in U.S.	21014  13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	USA 14. Race - Ame	rican Indian,
after d		Armed Forces?  1 ☐ Never Married 2 ☑ Married   1 ☐ Yes 2 ☑ No If Yes, Give	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White	e, etc.
ours aurali, c	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	X		Specify: Whi	
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yiene.	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)   Ele	ectrical Engineer		Aerospace Manufactu	ring
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Menid to Men	٩	Edmund Francis Shanahan Sr.		t (NMN)		Zin Carlal
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Inspertment of Heatth and Mental Hygiene. Inspertment of Heatth and Mental Hygiene. Inspertment of them 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.			Mailing Address <i>(Street and Number or Rura</i> B19 East Belcrest Roa		-	· /
s 1 an if Heal Item 2		20a. Method of Disposition 20b. Place of I			20c. Location - City or	
Page nent c		14⊾  Burial 2 □ Cremation 3 □ Removal from State	Memorial Gdn. 3/15	/2008	Bel Air, M	arvland
permit. Departr Importa any Inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility MC	Comas Fu	neral Home	e, P.A.
<u> </u>		23a. Part1. Enter the disease, or complications that caused the length. Do not	50 W. Broadway, Be			21014 Approximate
Dhysisian		shock, or heart inline. List only one cause on each line.		or respiratory arre		Interval Between Onset and Death
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is A te	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>)</b> .			ď
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The law requires that the death certificate ite has been signed by the attending phys bage 2 should be detached for use as the	Physician/Medical	IF FEMALE:				
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sician: The certificate har rector, page		25. Was case referred to medical	26. Place of Death		No 1 ☐ Yes	2 No
nysicia nis ceri direct	To Be	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Out;	Other		nce 6 □Other (Spe	ecify)
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director; p		29a. Certifier (Check only   Check				
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T wit		29b. Signature and title of certifier  Rollom	RES - 0000	1	•	
, 2		30. Name and address of person who completed cause of death (Item 23a) (T	vne Print)	- 10		/ 25-3
10		Dr. Bharat Rettan, MBBS SIN	21 HOSPITAL OF B	ALTIME	PRE	
Sta Registr		31. Date filed (Month, Day, Year)  MAR 1 4 2008  32 Registrar's Signature	Carles			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Schaeffer March 13, 2008 Anna 1:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1929 Shanklin Avenue <u>Parkville</u> Baltimore 1 Year Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Months Hours Director 181-14-9886 86 July 8, 1921 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 1 ☐ Yes 2 X No **Funeral Director** Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with i Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or item any injury or other traumatic event, the Medical Examiner must be none. U.S.A. 1929 Shanklin Avenue 21234 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 I 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 ₩ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kordich Hattie Bryner Andv ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1929 Shanklin Avenue Parkville, Maryland 21234 Daughter <u>Evalyn Kutluk</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Dulaney Valley
Memorial Gardens 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 3-15-2008 Timonium Maryland 21. Signature of Furnity I Service No. 1886 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician YEAV disease or condition resulting in death) OLON /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the build-transit completely filled in by the funeral director, page 2 should be detached for use as the build-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 X No 3 Probably 4 ☐Unknown TENSION Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed res 2 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 N Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State

29b. Signature and title of certifier

11 CHAZET

Registrar

Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

20234

TORKVILL

## Physician Modical Examiner    A. Facility Name (If not institution, pive street and number)   A. Clay, Town, or Location of Death   A. Clay Town, or Location of Death   A. Clay Town, or Location of Death   A. Clay Town, or Location of Death   A. Clay Town, or Location of Death   A. Clay Town, or Location of Death   A. Clay Town, or Location of Death   A. Clay Town, or Location   A. Clay Town, or Location   A. Clay Town, or Location   A. Clay Town, or Location   A. Clay Town or Location   A. Clay Tow			1 - State Registrar	Ce	rtificate of		F	leg. No. 2 (	008	08376
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100   State   100   CARPOLL	Director		216-03-1713 <sup>1□M 2</sup> X F				(Month, Day	, Year)		
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(General processing (Policy Control processing (	h with the 23a or 28a st be noti			325		58		_		iry?
(General processing (Policy Control processing (	J36 urs after deat al", or items ?	by	Armed Forces'  1 Never Married 2 Married  1 Yes 2 Yes If Yes Give	No			pecify Yes or No- p Rican, etc.)	Bla	ck, White, e	etc.
The parties is harmony (risid, Modes, Least)  CHARLES W. CONAWAY  BLANCE  FLOHR  BLANCE  FLOHR  190. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  14 E. COLLINS CIRCLE, FINKSBURG, MD 210.  20. Method of Disposition  1. Boniel 2 Cloceration 3 Clamemoral from State  Commission, Formatory or driber place)  1. Signature of Flohre  1. Signature of F	within 72 horiene.	ompleted	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or	(Give	kind of work done DO NOT use retired	during most of work d)	king			-
19. Mailro Advises (Sirect and Number or Flural Roade Number) (Typo Frant)  19. Mailro Advises (Sirect and Number or Flural Roade Number) (Typo Frant)  20. Head of Disposition 1 (Post of Struck	land Z	Be	17. Father's Name (First, Middle, Last)	. CONAWAY	7.					
The properties of the continue	# 13 # G		MADELINE FLOHR - COUS	IN 14 E	COLLI	NS CIRC	LE, FI	NKSBUR	G, M	D 21048
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Physician / Medical Examiner    Part   Company	and Deep and September 1	A) 15	Rymull Hotel	2 25	4 E. MA	IN ST.	WESTM	INSTER		21157 Approximate
Section   Sect	/Medical		Immediate Cause (Final disease or condition resulting in death)	tastatic	Carcu	one o	rophan	()		Onset and Death
FEMALE:   23c. If yes, outcome pf pregnancy   1   1   1   1   1   1   1   1   1	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as Due to (or							
1   Yes 2   No 3   Probably 4   Ur    24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Ur    25. Was case referred to medical examiner?   1   Yes 2   No 3   Probably 4   Ur    26. Place of Death (Check only one)    27. Manner of Death   Normalized   1   Yes 2   No 3   Probably 4   Ur    28a. Date of Injury at   Normalized   28b. Time of Injury at   Normali	<b>BOX</b> eath cer attendin for use	nysician/Med	23b. Was decedent pregnant in the past 12 mooths?  1 Yes 2 No 42c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death 3		у		1		,
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1	S 0 T	o Be	examiner? 1 ☐ Yes 2 ♣ No Hospital: 1 ♣ Inpati		II 3 DOX	er: 4 ☐ Nursing He	ome 5 ☐ Resid	ence 6 □Ot		0
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  312408	UNISION of all or Attending F safter death. I Director: Affer din by the funeral	Sertification:	1 Natural 5 Pending (Month, Date 2 Accident investigation 3 Suicide 6 Could not be 28e, Place of in	iury - At home, farm, str	M 1□		28f. Location (S	treet and Num		l Route Number,
1 than there was 038913 3/1408	he Hospit in 24 hours he Funera pletely fille		(Check only 2 Medical Examiner: On the basis of	of examination and/or in						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KHAUL TREIS! 245 STONER AVE. WESTMINSTER 2	To 1 To t	Σ	1. / 7 -		29c. Licens	3891	2			
State 31. Date filed (Month, Day, Year) 32. Palistrar's Signature			KHAUL +REIST	245 3	TO NE 1	R Aue	- WES	STMI	TZU	ER 2115

Registrar

State

MAR 1 4 2008

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** March bе 101 10 Za /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner ehab. BALTIMORE lenter 8. Date of Birth (Month, Day, Year If Under 24 Hrs. Hours Min. If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex ast birthday) **Funeral** Months Days 1 □ M 2 F 12. 080 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show 1XYes 2□No Director timor 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number SA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2DNo Specify. Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 ho Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natu any Injury or other traumatic event, I'm. Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland C Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be resham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md 21239 1266 altimore DAC altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Memorial 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 114/2008 4 Donation 5 Dother (Specify) Cemeter 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Jans, Fungral Chapel & Cremation Services ford Road Parkville 8800 Har Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of sician and burial-transit the death certificate be executed Due to (or as a consequence of) Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 4 Onknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No After this certificate Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No Hospital: 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: or Attending Natural (Month, Day Year) 5 Pending investigation M 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stage of DO 31) Date filed (Month, Day, Year) Registrar's Signature State 2098 MAR 14 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Theresa F. Thomas March 12, 2008 $11:15p^{M}$ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Riverview Care Center Essex Baltimore Co. 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🛭 F 218-07**-**5070 86 4-9-1921 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits 1 ¥ Yes 2 □ No N/ABaltimore 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 519 South Bradford Street 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 8 N/A Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Mack Anna (unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Snyder - Nephew 5685 Arnhem Road Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus Cem. Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final HPONIC OBSTRUCTIVE PULMONARY disease or condition resulting in death) Rue to (or as a consequence of): RESPIRATOR Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 🔀 No

Physician /Medical Examiner

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attending physician a for use as the burial

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To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

the death certificate be executed

Box 68760

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or Vital Records,

Division

**Physician** 

Examiner

**Funeral** 

Director

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/Medical

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Funeral

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Physician/Medical

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Completed

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Certification:

Medical

MD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

9 Unknown

4☐Pregnant at time of death 9☐Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 | Yes 2 | No 3 | Probably 4 | Unknown 24a. Was an autonsy performed? res 2 ☑ No

23e. Did tobacco use contribute to the cause of death?

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27 Manner of Death

Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation

and manner stated.

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1∐ Yes

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

 Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

1 X Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

29c. License number

D 27188

29d. Date signed (Month, Day, Year) March 14, 2008

and address of person who completed cause of death (Item 23a) (Type, Print)

Savinder K. Julka, 2 Market M.D.Place Dundalk, Maryland 21222 31. Date filed (Month, Day, Year)

State Registrar

MAR 14

6 ☐ Could not be



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARCH 6, 2008 /Medical THOMAS AUSTIN TURNER SR. 1:00 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 609 Dembytown Road Joppa Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months 1 XM 2 ☐ F **Director** 218-26-8823 77 July 12, 1930 Maryland Usual Residence of Decedent 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits show must be notified at 1 ☐ Yes 2 ☐ No Director 28a-f Maryland Harford Joppa 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Items 23a 609 Dembytown Road 21085 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Examiner Black, White, etc. e filed within 72 hours after all Hygiene." or Itel 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 3 Widowed 4 Divorced Black Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Carpenter Helper U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be ealth and Mental n and Mental ပ Henry Albert Turner Edith V. Peters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Mildred J. Turner / Wife 609 Dembytown Road, Joppa, Maryland 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 

Burial 2 □ Cremation 3 □ Removal from State Holly Hill Memorial Park 3-15-08 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ALZHEINERS 10 YEAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed burial-transi that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) P.O. Box 68760 Physician/Medical as the l IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar

J

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Bernhard Birnbaum

29c. License number

1321 Riverside Parkway, Belcamp, MD 21017

033088

29d. Date signed (Month, Day, Year)

08

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

08-01981 Barry Tevelow Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 08381

,		For State		Certif	ficate of	Death			Reg. No.	-	
Physician	/ 1	. Decedent's Name (First, Middle,L	ast)					2. Date of Month	Day	Year	3. Time of Death 1909 hrs
ખાંcal Examine		BARRY		TEV	ELOW		U61		10, 2008	C. County of	
	4	a. Facility Name (if not institution, g Howard County General			1	4b. City, Town, or Lo Clombia	Colu	umbia	ŀ	Howard	
Funeral	- 1			(In yrs. last	birthday)	If Under 1 Year Months Days	If Under :	) Aim	,	//DD/YYYY) 	9. Birthple STRICT
Director	L		X M 2 F	49	Yrs			09/1	7/195	8	OFFUNCOLUMBIA
ž.	101	Jsual Residence of Decedent  10a, State 10b, County		IOc. City, To	own or Locat	ion					10d. Inside City Limits
100 at		NC NEW HA	NOVER		WILMI	NGTON					1 Yes 2 No
ne Maryland or 28a-f show any fied at once.	[	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of Wha	t Country?
with the Maryland is 23a or 28a-f sho	Director	802 BRYCE COUR	T. #G			2840	05			USA	
death with the Maryland or items 23a or 28a-f sho must be notified at once.	ᇎ	11. Marital Status	12. Was Decedent B	ever in U.S.		as Decedent of Hisp res, specify Cuban,				14. Race - White,	American Indian, Black, etc.
death	Funeral	1 Never Married 2 X Marri	1 Yes 2	No		Yes 2 X No				Specify:	WHITE
s afte	~	3 Widowed 4 Divorce  15. Decedent's Education (Specify	ed If Yes, Give Year or Dates:	pleted) 1	6a. Deceder	nt's Usual Occupation		nd of work done	16b.		iness/Industry
72 hour	Completed	Elementary/Secondary (0-12)	College (1-4 or 5			nost of working life.		se retired)			
5-0036 led within 72 hou tygiene. other than "nat the Medital Exa	립		4		SELF	EMPLOYE					HNOLOGY
		17. Father's Name (First, Middle, La FRANK	TEVELO	141		1		Name (First, Mid	idle, Maide		NER
2121 uld be fii Mental H marked c event,	8	19a. Informant's Name/Relationship		VV .	19b. Mailin	ng Address (Street			e Number,		
O sh or is is	٩	CARLA TEVELOW /			I	OAKWOOD			, DAY	YTON.	MD 21036
and and lealth item	f	20a. Method of Disposition				sition (Name of cen	netery,	Date	200	. Location -	City or Town, State
Baltimore, permit. Pages I a Department of He Important: If ite injury or other tr	1	1 X Burial 2 Cremation 4 Donation 5 Other Spee		PAK	H EL M K	YEMOR'I AL	(	03/13/20	08   R	ANDALI	STOWN, MD
Baltil permit. Departm Importa	ı	21. Signature of Funeral Service Li	ensee		22.	Name and Address		JUL	LEVI	NSON &	BROS., INC.
	_	23a. Part I. Enter the disease, or co	amplications that caused	the death. I	Do not enter	8900 RE	ISTER such as ca	STOWN RO	DAD - ory arrest, s	PIKES shock, or hea	art Approximate Interval
Physician / Lodical	1	failure. List only one cause or	each line.						•		Between Onset and Death
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		Sequentially list conditions,	b								
	ie	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of)	:						
- H	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of)	:						
and and		Tprvprp	d. 4C	per	me g8.	77 3-20-0	8 vt	23a,27 pe	r ME g8	378 4/2/	/08 a <b>n</b> ih
760, cate be exc physician he burial	Medical	X UNPENDED  IF FEMALE:	23c. If yes, outcor					, .		23d. Date of	
1876 rtificat ing ph as the		23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 F	etal death 3	Ectopic	pregnancy		Month	Day Year
Box 687 death certific the attending ed for use as the	sician	1 Yes 2 No 9 Unkn	own 9 Unknown	time of dea	ith 5 (	Other (Specify)					
O. Boat the de	P	Part II. Other significant condition		h but not re	sulting in the	underlying cause (	given in Pa				ibute to the cause of death?
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eco ne law te has	Ĕ							1	performed Yes 2	m, .	death?  ✓ Yes 2 No
tal Recition: The lactificate lactor, page	Be	25. Was case referred to medical				26.Place		(Check only one			
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T of Vi ding Physi After this funeral dir	T:UC	27. Manner of Death  1 X Natural 5 Pendi	28a. Date of Inji (Month, Day,)	ury Year)	28b. Time o		ry at Work Yes 2	.	scribe now	injury occur	ieu
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Division of Vital Records, tal or Attending Physician: The law requir rs after death.  sal Director: After this certificate has been seled in by the funeral director, page 2 should be	Certification:	deterr	not be	njury - Actio	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		J,		Fown, State		
Hospi 24 hou Funer tely fil		29a. Certifier	ysician: To the best of m	ny knowledg	ge, death occ	curred at the time, d	ate and pla	ace, and due to t	he cause(s	) and manne	er as stated.
To the within To the comple	Medical	one) 2 Medical Exam	niner: On the basis of exa and manner stated	amination ar	nd/or investi						ned (Month, Day, Year)
74	ž	29b. Signature and title of certifier	, mp			29c. Licen	se number .M.E.		- 1	ya. Date sigi March 11,	
n orand		my w		1 -15 (1)	00-1		v				
3 opend		30. Name and address of person Ling Li, MD Assistar	who completed cause of it Medical Examine		23a) Penn Str	eet, Baltimore,	MD 212	201			
S	ate	31. Date filed (Month, Day Year)	32 Registr	ar's Signat	. 4	will !					
Regist		LERTH 1 /	2008	الماكم الم	13/20						

DHMH 17 Rev 1/2001 OCME 2006

OCME

			1 - For State Registrer	State of	Marylan	d / Depa <i>Cei</i>	artment o	f Health of Deat	and I	Mental Hyg	giene Reg. No.	008	083	882
	Physici	an	1. Decedent's Name (First, Middle, La							2. Date of Dea		Year	3. Time of	
	/Medic			anna J.		rne				March	10°,	2008	7:20	Ам
П	Examir	er	4a. Facility Name (If not institution, given Manor Care Poto		er)		4b. City, Tow	n, or Locatio COMAC	n of Death	1		ounty of Deat		
	Funeral		5. Social Security Number 6. S		Age (In yrs. I	last birthday)	If Under 1 Ye		ler 24 Hrs.	8. Date of Birt		9. Birti	hplace (State of	or Foreign
	Director			□M 2፟∭AF	96	Yrs.	Months Da	ys Hour	s Min.	8. Date of Birt (Month, Day December	у, <i>Үөаг)</i> 12 <b>,</b> 19	Co	untry)	3
	pu 🖈		Usual Residence of Decedent  10a. State 10b. County		100 Cit	, Town or Lo							404 1-14-0	in a Linning
	shov	7	,		Toc. City								10d. Inside C 1 ☐ Yes	
	28e-f	Director	Maryland Montgot  10e. Street and Number	nery		Beth	10f. Zip Coo	lo.			10g Citize	on of What Co		
	aa or		6621 Millwood Ro	ad			101. Zip Coc	2081	7			ed Sta	•	
	death ms 2	Funeral	11. Marital Status	12. Was Decede		S. 13. )	Was Decedent			pecify Yes or No- Rican, etc.)		l. Race - Ame	rican Indian,	
٥	be filed within 72 hours after death with the Maryland lat Hyglene. d other then "natural", or Itams 23a or 28e-f show event, The Mcdical Examiner must be notified at		1 Never Married 2 Married	Armed Force 1 ☐ Yes 2 If Yes, Give			fYes, specify ( I□Yes 2【X			o Hican, etc.)		Black, White		
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0	illed Hygi other	Be C	17. Father's Name (First, Middle, Last)					-	ther's Nam	ne (First, Middle,	Maiden S	umame)		
<u>la</u>	should be fand Mental H s marked of	To B	Armin Mikes					K1	ement	ina Bet	h1en			
Maryland 21215-0036	2 sho and N is ma	•	19a. Informant's Name/Relationship (	* * * * * * * * * * * * * * * * * * * *		19b. Mailin	g Address (Str	eet and Nun	nber or Ru	ral Route Numbe	r, City or	Town, State, Z	ip Code)	
_	and ealth m 27		Geza Teleki / Son						-	thesda,				
0	ges 1 t of H If ites or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐	Removal from Sta	ate Ce	emetery, cren	sition (Name or natory or other	place)		n 11,		ation - City or		
Baitimore,	t Partmen		'4 □Donation 5 □ Other (Specify		Mont		Crematori		1				larylan	
ga	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic engine.		21. Signature of Funefal Service Licer	rest	M0130	5 75	57 Wiscor	sin Ave	enue,	ral Home/: Bethesda,	Maryl	da-Chevy and 2081	Chase, 4-3501	Inc.
			23a. Part1 Enter the disease, or com shoot, or heart failure. List only	olications that cau one cause on eac	sed the death h line.	n. Do not ent	er the mode of	dying, such	as cardiac	or respiratory ar	rest,		Approximat Interval Bet Onset and	ween
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X O D	leath certific attending p	hysiclan/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal	death 3	Ectopic pregna				23	d. Date of deli Month	,	Year
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7.	w requires that the dispension signed by the should be detached	۵.	Part II. Other significant conditions of	ontributing to deat	h but not resu	ulting in the ur	iderlying cause	given in Pai	rt I.	23e. Did to	bacco use	e contribute to	the cause of c	death?
S	uires signa ld be	d by	•			3	,	•		1 🗆 Y	′es 2 🗆	No 3∏Pro	obably 4 10	Unknown
cords	≥ Q ts	ompleted								24a. Was	an	24b. Were au	topsy findings	available
Ė	The law ate has b page 2 st	duic								autop perfor	sy med?	prior to death?	completion of c	ause of
		o C	25. Was case referred to medical					26. Pla	ice of Dea	1 ☐ Yes	2 No	1 🗆 Yes	285No	
_	y s	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 🗆 Inpa	atient 2 🗆 E	ER/Outpatien	3 DOA	Othor		ome 5 Resid		Other (Spec	cify)	
0	ng Ph Iter th neral		27. Manner of Death 1   Matural 5 □ Pending	28a. Date of I	njury Day Year)	28b. Time of Injury	28c. li	njury at Vork?		28d. Describe h	low injury	occurred	4	e e
0	Attendii death. ctor: Ai y the fu	catle	2 ☐ Accident investigation				M 1	☐Yes 2	□No				8	
UNISION	or Att	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of	Injury - At hor etc. (Specify	me, farm, stre	et, factory, offi	CO		28f. Location (S City or Tow	Street and . m, State)	Number or Ru	ral Route Num	iber,
_	pital	0	29a. Certifier 1 Certifying Ph	veicien: To the be	et of my know	wledge doath	aggurand at the	time data	and alaca	and due to the			atatad	
	To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funerel	Medical	(Check only 2 Medical Exemone)	iner: On the basis and manner	s of examinat	ion and/or inv	estigation, in m	y opinion, d	eath occur	red at the time,	date and p	lace, and due	to the cause(s	5)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	)				ense numbe			29d. Date	signed (Month	n, Day, Year)	
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η	50		30. Name and address of person who							c: 0	. 1		1n	
Ĭ	Sta	to.	31. Date filed (Month, Day, Year)	32. Regi	SO Ce	ure	HYCHU	山,井	1-17,	Silver	6771	ry o	0201	02.
	Registr	_	MAR 1 4 2008	Section 1	4 6	647						,		

			1 - For State Registrar	State of M	aryland /		artment of H <i>rtificate of L</i>			giene Reg. No.	008	08383
	38.41		Decedent's Name (First, Middle, La	st)					2. Date of Dea	ath		3. Time of Death
	Physici: /Medic		NANCY F	RESEN		W	HITMEY	<u>'</u>	Month MARCIA	Day ( O	Year	1430 PM
	Examin		4a. Facility Name (If not institution, giv	e street and number)		_	4b. City, Town, or				inty of Deat	h
1			Shady Grove Adv				Rockv		lan i (B)		tgome	
	Funeral Director		021 02 1000	Sex 7. As	ge (In yrs. last 77	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bird (Month, Da Sept.	$\overset{\text{h. }}{15},\overset{\text{Year.}}{193}$	9. Birtl Co. P:	hplace (State or Foreign untry) anama
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Te	own or Lo	cation					10d. Inside City Limits
	Maryl f sho ied a	Ď	Maryland Montgo	merv	Gait	hers	burg					1 XYes 2 No
	r 28a-	Directo	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Co	untry?
	h witl 23a o st be	al D	16733 Shea Lane	Э			2	20877	1	Unite	d Sta	ates
	ems	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. \	Was Decedent of His f Yes, specify Cuba	spanic Origin? (Sp n. Mexican, Puert				rican Indian,
220	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mertal Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show If item 27 is marked other than "natural", or items 2 be notified at or other traumatte event, the Me-K-al Examiner must be notified at	by Fu	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 🔀 If Yes, Give Year or Dates:	No	- 1	1 ☐ Yes 21☑ No	Specify:	or mounty overly		ecify: Whi	•
5	72 hou	ted	15. Decedent's Ed (Specify only highest gra	ducation	1	6a. Deced	lent's Usual Occupa	ation	king	16b. Kind o	of Business/I	Industry
7	ithin 7 ne. nan "r	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work done d OO NOT use retired,		Killy	_		
V	led w lygier her th nt, the	ပ္ပ		4		H	omemake:		- /Final 8814-0-		Hom	e
2	2 should be filed with and Mental Hygiene. is marked other than aumatic event, the N	Be	17. Father's Name (First, Middle, Last,	)				18. Mother's Nam			name)	
Š	should be and Mental marked o	은	Henry Fresen  19a. Informant's Name/Relationship (	Type. Print)	1	19b. Mailin	ig Address (Street a	Isabel			wn State Z	(in Code)
2	and 2 s ealth ar m 27 is ner trau			ısband			3 Shea I				MD 20	
ָנ ב	es 1 a of Hea fitem rothe	- N	20a. Method of Disposition		20b. Place		sition (Name of natory or other place		Date	20c. Location		
2	Pages nent of int: If its iry or o		1 ☐ Burial 2 【3 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		'		n Cremat	marc	h 12, 008	Frede	rick	,Maryland
משו	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Lice	1See	4,000.							t Cody P.A.
Í	40/20		23a. art1. Enter the diseas or m shock, or heart failure.	plications that cause one cause on each	d the death. Dine.						SIICK	Approximate Interval Between
	Physician		Immediate Cruse (Final disease or condition resulting in death)	_a	To	Lac-	nan					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequen	ce of):	0/0 0 5					. 1
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Ś	ficate be executed physician and is the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as	a consequen	ce of):						
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5	e as t	Med	IF FEMALE:					- 1	,			
	The law requires that the death certificate be executed ite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	ath 3	Ectopic pregnancy Other (specify)			23d.	Date of deli Month	ivery Day Year
	ires that the de signed by the a I be detached f		Part II. Other significant conditions of	contributing to death b	out not resulting	a in the ur	nderlying cause give	n in Part I.	23e. Did to	obacco use o	contribute to	the cause of death?
ָה ב	w requires been signe should be	ed by		_					1 🗆 🕆	∕es 2⊠N	o 3□Pr	obably 4 Unknown
2	law re	Completed	Luca	son's Dis	2				24a. Was		4b. Were au	topsy findings available completion of cause of
	Physician: The lar this certificate has ral director, page 2	No.	71		· · · · · · · · · · · · · · · · · · ·				perfo	rmed? 2 No	death? 1 ∐ Yes	
3	ctor,	Be (	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only o	ne)		
-	hysik this o	2	1 Yes 2 No		ent 2 ER/			4 Li Nursing H	ome 5□Resid			cify)
	nding P tth. r: After t e funera	tion:	27. Manner of Death  1	28a. Date of Inji (Month, Da	ay Year) 28	b. Time of Injury	Work	rat ? /es 2 ∐ No	28d. Describe I	now injury oc	curred	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificat completely filled in by the funeral director, p	Certification:	3 Suicide 6 Could not be determined	28e. Place of in	jury - At home tc. (Specify)	, farm, stre	eet, factory, office		28f. Location (S City or Tox		umber or Ru	ıral Route Number,
	Hospita 24 hours Funera etely fille	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best niner: On the basis of and manner st	of examination	dge, death and/or in	occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and date and pla	d manner as ace, and due	stated. to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	- 1			29c. License	number		29d. Date si	gned (Monti	h, Day, Year)
	/		1 minus	Il bonney,	MO		D 000	065830	,	MARCH	10	2009
	n 5		30. Name and address of person who			a) (Type,						
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			MMI/ T I FOR	- Supplier	2- 40-13	500						

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

Be

MD

"natural", or items 23a or 28a-f sh dical Examiner must be notified

is marked other

permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra

filed within 72 hours after death Hygiene.

Pages 1 and 2 should be rent of Health and Mental

21215-0036

Baltimore, Maryland

Box 68760

Division or Vital Records, P.O.

certificate be executed

sician and burial-tran physician the attending phase as t þ has

certificate To the Hospital or Attending Physician: within 24 hours after death. After

Examine Physician/Medical 2 Completed Be ဥ Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Medical

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown 25. Was case referred to medical examiner?

1 🗌 Yes

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

2 No

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2 No 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

seleda mo

D37717

29d. Datę signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FERNANDO A DELLASO

LINTITICUM

31. Date filed (Month, Day, Year) State MAR 1 4 2008 Registrar

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For

•	٠,	9.01.0	0	0	13	0	
		Reg. No.	6	U	U	0	

00225

			Registrar		$C\epsilon$	ertificate of	Death	_	Reg. No. 🚄 🔱	00 00000
57			1. Decedent's Name (First, Middle, L.	ast)				2. Date of De		3. Time of Death
п	Physici		Henry Dani	el Wil	liams			Month 03	extstyle  e	Year 2008 1:00A M
J.	/Medi Examir		4a. Facility Name (If not institution, gi	ve street and number	er)	4b. City, Town, o	or Location of Deatl	1	4c. County	of Death
	LAGIIII	ICI	Glen Burnie Heal			Glen	Burnie		Anr	ne Arundel
					Age (In yrs. last birthda)			8. Date of Birl	th	
ш	Funeral Director		,	1 X M 2 □ F	89 Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	Birthplace (State or Foreign Country)     MD
in.	Director		Usual Residence of Decedent		09			06-25-	1910	, im
	and w		10a. State 10b. County		10c. City, Town or I	.ocation				10d. Inside City Limits
	faryl sho	5	MD Anne A	T o L	Clan	Burnie				1 ☐ Yes 2 ☑ No
	he N 28a-1 otifi	Director		Lunder	Gren				10- 011	
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at	Ö	10e. Street and Number			10f. Zip Code			10g. Citizen of V	
	ath v	ā	520 Hawthorne R			2109				.S.A.
	r de	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S. 13	. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S Jan, Mexican, Puerl	pecify Yes or No o Rican, etc.)	- 14. Raci	e - American Indian, ck, White, etc.
9	afte or It		1 ☐ Never Married 2 【 Married	1 X Yes 2 If Yes, Give	□No	1 ☐ Yes 2X No			Specify	
21215-0036	ours ral",	d by	3 Widowed 4 Divorced	Year or Date	S:				Specify	White
5-0	72 h natu Ilcal	Completed	15. Decedent's E (Specify only highest g.	Education rade completed)	16a. Dec	edent's Usual Occup	pation during most of wor	kina	16b. Kind of Bu	usiness/Industry
2	thin an "	٩	Elementary/Secondary (0-12)	College (1-4	or 5+)	e kind of work done DO NOT use retire		9		
21	filed withi Hygiene. ther than int, the M	ĕ	12		G	eneral Fo	reman		Manui	facturing
	othe /ent,	Be (	17. Father's Name (First, Middle, Las	it)			18. Mother's Nar	ne (First, Middle,	Maiden Surnam	ne)
<u>a</u>	id be sentants in the second i	To B	Elmer A. Willi	ams			Mary	A. Hook	S	
Maryland	d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship	(Type. Print)	19b. Mai	ling Address (Street	and Number or Ru	ıral Route Numb	er, City or Town,	State, Zip Code)
$\mathbb{Z}$			Mrs. Margaret V.	Williams	/ Wife 52	0 Hawthor	ne Road	Lint	hicum, N	4D 21090
o o	s 1 and 2 f Health item 27 I		20a. Method of Disposition		20b. Place of Dist	position (Name of	1	Date	20c. Location -	City or Town, State
آو	ages nt of if it		1X Bunal 2 ☐ Cremation 3			ematory or other pla Veterans		17-2008		ville, MD
ţ	t. Pe tmel tant tant		4 □ Donation 5 □ Other (Spec							
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		21. Signature of Funeral Service Lice	ensee				ngleton	Funeral	& Cremation Srv
	σΩ <u>=</u> « ο		MCCONULL M	MAINE		1 2nd Ave			rnie, M	
			23a. Part1. Enter the disease, or con shock, or heart failure. List onl	mplications that cau y one cause on eac	sed the death. Do not e n line.	nter the mode of dyi	ng, such as cardia	or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Ma	20.000010	0 10	PRACT	7 (1 ) /	,	Onset and Death
1	/Medical		resulting in death)	Due to (or	as a consequence of):	)	1-12/10	10101		11000
	Examiner			· CC2C	IONIAMY	ART 173	ny C	15130	イノラ	20 417An
4		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consequence of):		,			
V	uted d ansit	Ē	Cause (Disease or injury that initiated events	6						
Ć.	n an ial-tr	Examin	resulting in death) Last	Due to (or	as a consequence of):					
68760,	certificate be executed ding physician and ise as the burial-transit		•	d						
89	ficate phy s the	n/Medical		u,						
X	nding use a	Ž	IF FEMALE:	23c. If yes, outco	me pf pregnancy				23d Dat	te of delivery
ğ	leath atter for u	-	23b. Was decedent pregnant in the past 12 months?			☐ Ectopic pregnand ☐ Other (specify) _	y			onth Day Year
o.	the d	Physicia	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknow						
P.0	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	P.	Part II. Other significant conditions	contributing to deat	h but not resulting in the	underlying cause giv	ven in Part I	23e. Did t	obacco use cont	ribute to the cause of death?
JS,	ires t	by		3		, , ,		1 🗆	Yes 2□No	3 ☐ Probably 4 ☐ Onknown
or o	requi	Completed		100 11				• —		Tobably 4 Children
ec	e law has b	ple						24a. Was autor	nsv 📥 I	Were autopsy findings available prior to completion of cause of
Æ	The I	no.						perfo	ormed?	death? 1 □ Yes 2 □ No
ta	slcian: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place of Dea	ath (Check only o		
or Vital Records,	Physician: this certificated director, in	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inp	atient 2 ☐ ER/Outpati	ent 3 DOA Oth	ner: 4 Nursing H	lome 5 ☐ Resi	dence 6 □Oth	er (Specify)
0	g Ph er th eral		27. Manner of Death	28a. Date of					how injury occur	
Division	Attending Frdeath. ector: After by the funer	tio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year) Injury		Yes 2 □ No			
İS	Atter dea sctor	fica	3 ☐ Suicide 6 ☐ Could not	28e. Place of	injury - At home, farm, s	treet, factory, office		28f. Location (	Street and Numb	per or Rural Route Number,
Ö	after Dire	Certification:	4 ☐ Homicide determine	building.	etc. (Specify)			City or Tou	wn, State)	
	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /		29a. Certifier 1 Certifying F	hysician: To the be	est of my knowledge, dea	ath occurred at the t	ime, date and place	e, and due to the	cause(s) and ma	anner as stated.
	24 h 24 h e Fui etely	Medical	(Check only 2 Medical Exa	aminer: On the basi and manner	s of examination and/or stated.	investigation, in my	opinion, death occ	urred at the time,	date and place,	and due to the cause(s)
	o th o th o mp	Me	29b. Signature and title of certifier			29c. Licen:	se number		29d. Date signe	d (Month, Day, Year)
	⊢ ≶ ⊢ ō		NV. Xl	141.		n	7 (2		MARCH	12 5000
	7		OO Name and address of account	o completed source	of dooth (Itam 22s) (**	Drint)	100	5	11-11-1	19 2008
(	1		30. Name and address of person who		or death (item 23a) (Type	a, emin	7000-	20	. –	12, 2008 21096 1CUT, 170
	C.	ate	31. Date filed (Month, Day, Year)		istrar's Signature	16' [	111/2013	0(1).	-INTH	1007, 110)

DHMH 17 Rev 1/2001

Registrar

MAR 1 4 2008

Physician   The Registrar   Certificate of Death   Reg. No. 2 0 8 0 6 1	O M  or Foreign  ity Limits 2 ⅓No
Physician /Medical Examiner  William Harrington Williams  William Harrington Williams  March 12, Day 2008 Year 06:3  4a. Facility Name (If not institution, give street and number)  Suburban Hospital  Suburban Hospital  Social Security Number 6. Sex 1 T. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. (Month, Day, Year) July 12, 1929 Virginia  Usual Residence of Decedent  William Harrington Williams  March 12, Day 2008 Year 06:3  4c. County of Death Montgomery  4d. County of Death Montgomery	O M  or Foreign  ity Limits 2 ⅓No
Aa. Facility Name (If not institution, give street and number)   Ab. City, Town, or Location of Death   Ac. County of Death   Ac.	or Foreign ity Limits 2 ⅓No
Suburban Hospital  Suburban Hosp	ity Limits 2 13 No
Funeral Director   5. Social Security Number   220-30-7778   1 2 1 5 20 5 20 5 20 5 20 5 20 5 20 5 2	ity Limits 2 13 No
Director 220-30-7778   112M 2   F   78   Yrs.   World S   Says	2 TNO
To the state of th	2 TNO
Maryland Montgomery    Maryland Montgomery Maryland Montgomery   Maryland	2 TNO
Maryland   Montgomery   Rockville   106. Zip Code   109. Citizen of What Country?   109. Street and Number   106. Zip Code   109. Citizen of What Country?   109. Street and Number   106. Zip Code   109. Citizen of What Country?   109. Street and Number   106. Zip Code   109. Citizen of What Country?   109. Street and Number   106. Zip Code   109. Citizen of What Country?   109. Street and Number   106. Zip Code   109. Citizen of What Country?   109. Street and Number   106. Zip Code   109. Citizen of What Country?   109. Street and Number   109. Citizen of What Country?   109. Citizen of What Country?   109. Citizen of What Country?   109. Street and Number   109. Citizen of What Country?   109. Citizen of What Country?   109. Citizen of What Country?   109. Citizen of What Country?   109. Citizen of What Country?   109. Citizen of What Country   109. Citizen of What Country?   109. Citizen	
Source   S	i
12. Was Decedent Ever in U.S. Armed Forces?   12. Was Decedent Ever in U.S. Armed Forces?   12. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify: White   12. Was Decedent Ever in U.S. Armed Forces?   12. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify: White   12. Was Decedent Ever in U.S. Armed Forces?   12. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify: White   12. Was Decedent Ever in U.S. Armed Forces?   12. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify: White   12. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify: White   12. Was Decedent of Hispanic Origin? (Specify: White   12. Was Decedent of Hispanic Origi	i
1   Mary   1   Mary	i
Specify: White    Specify	i
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working lifle. Do NOT use retired)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  18. Mother's Name (First, Middle, Maiden Surname)  19a. Informant's Name/Relationship (Type. Print) sister—  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19c. Method of Disposition  19a. Method of Disposition  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19c. Place of Disposition (Name of comelery, Crematory or other place)  19c. Place of Disposition (Name of comelery, Crematory or other place)  19d. March 14,  19	
Elementary/Secondary (0-12)  College (1-4or 5+)  Chef  Restaurant  Chef  To Father's Name (First, Middle, Maiden Surname)  Garland Basil Williams  Garland Basil Williams  Garland Basil Williams  Garland Basil Williams  Garland Basil Williams  Garland Basil Williams  Garland Basil Williams  The Ima Florine Williams/in-law  The Ima Florine Williams/in-law  20a. Method of Disposition  1 Burial 2 Stremation 3 Removal from State  1 Date  20b. Place of Disposition (Name of cemelery, crematory or other place)  1 Date  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. March 14,  Restaurant  The Ima Florine Williams/in-law  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Horden of Disposition  1 Burial 2 Stremation 3 Removal from State  4 Donation 5 Other (Species)  Montgomery Crematorium The 2008  Rethesda Marylan	ำ
The limit of Disposition  The limit of Dispo	า
Garland Basil Williams  Grace Margaret Burke  Garland Basil Williams  Grace Margaret Burke  19a. Informant's Name/Relationship (Type. Print) sister— Thelma Florine Williams/in-law  20b. Place of Disposition (Name of cemetery, crematory or other place)  10b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Thelma Florine Williams/in-law  20c. Location - City or Town, State  20d. Method of Disposition  1 Burial 2 Toronant's Name/Relationship (Type. Print) sister—  10b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  March 14,  10b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Hording Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  20c. Location - City or Town, State  20d. March 14,  Rethesda Marylan  Rethesda Marylan	
19a. Informant's Name/Relationship (Type. Print) sister— 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  The Ima Florine Williams/in-law 5009 Randolph Rd., Rockville, Maryland 20852  20a. Method of Disposition 20a. Method of Disposition 3 Removal from State 4 Donation 5 Other (Specific Address) Montgomery (Trematorium, Inc. 2008)  Rethered Maryland 20854	i
The Ima Florine Williams/in-law 5009 Randolph Rd., Rockville, Maryland 20852  20a. Method of Disposition  20a. Method of Disposition    Date   Commeltery, Crematory of other place)   Commeltery, Crematory of Other (Specific to the place)   Commeltery, Crematory of Other (Specifi	ำ
20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State	ำ
E 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	า
E & 5	AND THE REAL PROPERTY.
21. Signature of Funeral Service icense M00896  22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, 7557 Wisconsin Ave., Bethesda, MD 20814-350	
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximation that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Bit interva	
Immediate Cause (Final	Death
/Medical resulting in death)  Due to (or as a consequence of):	
Examiner  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inlitated events  Due to (or as a consequence of):  Cause (Disease or injury that inlitated events)	
S of that illimated events c. Due to (or as a consequence of):	
Efficação por de production de la constant de la co	
To be the property of the prop	.,
O O O O O O O O O O O O O O O O O O O	Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	death?
S S S S S S S S S S S S S S S S S S S	
1   Yes   2   No   3   Probably   4	available
24a. Was all autopsy into autopsy performed? performed? death?	ause of
1	
25. Was case referred to medical examiner?  1   Yes   25   No   1   Yes   25   No   1   Yes   25   No   1   Yes   25   No   1   Yes   26   No   1   Yes   27   No   27   No   28   Date of Injury   28	
The first of the f	
200   201	
286. Date of Injury    State   Place of Injury   Place	nber,
29a. Certifier 29a. Detailed and place, and due to the cause(s) and manner as stated. 29a. Detailed and place, and due to the cause and due to the cause and due to the cause and due to the cause and due to the cause and due to the cause and due to the cause and due to the c	5)
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	
Imperer 1 00057124 3112108	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Truong Bao, M.D., 9715 Medical Center Drive, Rockville, Maryland 20850	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Registrar MAR 1 4 2008 Market Mr. Acceptance MAR 1 4 2008	

Discounts where (First, Motion), Last)  Physician (Motion)  Richard D. Wagner  Richard D. Wagner  Richard D. Wagner  Richard B. Cay, Town, or Location of Death  Ranch 6, 2008  Rober Ca. House  Function  Fun	37
Account of Death   Account of	ath
Second property   Second pro	М
Director    Total Control   Control	
100. State   100. County   100. City, Town or Location   100. City Code	oreign
17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Surmame)   18. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   194. Thorse Shoe Drive, Vienna, Va. 22182   20a. Method of Disposition   19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   194. Thorse Shoe Drive, Vienna, Va. 22182   20a. Method of Disposition   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State   19b. Place of Disposition (Name of Disposition (Name of Disposition)   19b. Place of Disposition (Name of Disposition)   19b. Place of Disposition (Name of Disposition)   19b. Place of Disposition (Name of Disposition)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State   19b. Place of Disposition (Name of Disposition)   19b. Place of Dispos	imits
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24a. Was an autopsy findings avail prior to completion of cause	ilable
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P 1	
27. Manner of Death  28a. Date of Injury (Month, Day Year)  28b. Time of Injury at Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred	
Significant Street and Number or Bural Route Number of Bural Route	_
27. Manner of Death    X   Natural   2   Accident   3   Suicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   5   Pending investigation   28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28b. Injury at Work?   28b. Injury at Work?   1   Yes 2   No   28b. Place of Injury - At home, farm, street, factory, office   28b. Location (Street and Number or Rural Route Number, City or Town, State)   28b. Location (Street and Number or Rural Route Number, City or Town, State)   28b. Describe how injury occurred   28b. Describe how injury occu	
The state of the s	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
Brenere Wrollewst, MD D0064615 March 12, 2008	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  G. Wroblewski, M.D. 1365 Piccard Drive, Rockville, Maryland	
State Registrar MAR 1 4 2008 32 Registrar's Signature	

			1- For Amend Items State of Maryland Department of Departm		
	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 3. Time of Death		
I A	/Medic	cal	4. Facility Name (If not institution, give street and number)  4. County of Death 4. County of Death 4. County of Death 4. County of Death 4. County of Death 4. County of Death 4. County of Death		
	Examir	ier	4a. Facility Name (If not institution, give street and number)  28 Rollwin Road  4b. City, Town, or Location of Death  Windsor Mill  Baltimore		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 9. Birthplace (State of Foreign Country) Mn.		
	and ww		Usual Residence of Decedent  10a. State		
	a-f sho	ctor	ma Baltimore Windsor Mill 10 Yes 2 20 No		
	h with the	Funeral Director	10e. Street and Number  28 Rollwin Road  10f. Zip Code 21244  USA		
ပ္	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notitled at		11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1		
21215-0036	hours a tural", c al Exan	ed by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: Specify: Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry		
215	thin 72 ie. an "na Medic	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of working life. DO NOT use retired)  Mortgage		
CA	iled wi Hygien ther th nt, the		12th gyade Hyeaks Loan Officer Company  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)		
/lanc	d 2 should be filed within "th and Mental Hygiene." 7 Is marked other than "traumatic event, the Mec	To Be	Oliver Austin Eula Wheder		
	s 1 and 2 should if Health and Mer item 27 is marke other traumatic	ľ	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Avnold A. Wright/Hubband  28 Rollwin Road Window Mill, MD 21244		
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If Item 27 I any Injury or other tra once.		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State		
Him	permit. Pages 1 Department of H Important: If Ite any Injury or ot once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Willin C. Greene Funeral Services		
Ba	permi Depar Impor any Ir		Vaughn C. Lister 8728 Liberty Road Randallstown MD 21133		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or least failure. List only one caus on each line.  Approximate Interval Between Onset and Death Onset and Death		
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or man consequence of):		
	Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of):		
	cuted Id ransit	Examiner	Cause. Enter Underlying Cause (Disease or Injury that initiated events  c. IMMU > 2 COMDOM Se		
8760,	cate be executed physician and the burial-transit				resulting in death) Last Due to (or as a consequence of):
9	tificate ig phys as the	ledical	d.		
.O. Box	The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		
<u>α</u>	res that igned by be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1  Yes 2 PM 3 Probably 4 Unknown		
Vital Records,	w requir been si should I	Completed	The Mariane		
l Re		omo	24a. Was an autopsy findings available prior to completion of cause of performed?  1		
Vita	Physician: The this certificate har director, page	Be	25. Was case referred to medical examiner?  Hospital: Hospital: 1 Descript 2 FR/Output 2 F		
ō	Phys rthis raldi	n: To	25. Manner of Death  28a. Date of Injury  28b. Time of  28c. Injury at  28d. Describe how injury occurred		
Division	or Attending ifter death. Director: Aftel in by the fune	catio	2 Accident investigation M 1 Yes 2 No		
Divi	al or At after d Direct d in by	Certification:	3 Suicide 4 Homicide determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier  (Check only of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
8	vithir To th comp	Me	29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)		
	(0)		30. Name and address/of person who completed cause of death (Item 23a) (Type, Print)		
			Harry M. Harris 300 Armory Place Suile 3 ( Belt M. 2(20)		
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar & Signature MAR 1 4 2008		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 26 per md 9877 3-14-08 vr.
State of Maryland? Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Thomas Charles Walker Sr. 2008 22:34 March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days M DM 2□F Director 218-32-8073 76 June 20, 1931 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 ☐ Yes 2√∑ No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1310 Sheridan Place Unit 207 21015 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items in injury or other traument. 1 TYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Plant Supervisor County Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Challie Thomas Walker Hazel Bernice Hash 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1310 Sheridan Place Unit 207, Bel Air, MD 21015 Bertha H. Walker / Wife 20a. Method of Disposition 1 ☑ Burial 2 ☐ Gremation 4 ☐ Donation 5 ☑ Other (S 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 Demoval from State Bel Air Memorial Grdn 3-12-08 Other (Specify) Bel Air, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009 21. Signature of Fv Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) pulmonary disea. Physician /Medical Due to (or as a consequence of): Examiner Muonar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 Due to (or as a consequence of): physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2□ 0c\_ 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Acsidence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Destrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State

Registrar

31. Date filed (Month, Day, Year)

32. Pregistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Knight.

strar's Signature

104 Plumtree Rd Ste. 102 Bel Air, MO

			1 = For State Registrar	Ce	ertificate of		, ,	g. No.2008	08390	
	Physicia	an	1. Decedent's Name (First, Middle, Last)				Date of Death Month Murch	Day Year	3. Time of Death	
	/Medic	al	4a. Facility Name (Nach institution, give street and numb	ner)	4h. City Town, o	r Location of Death	March	12 <sup>th</sup> 2008 4c. County of Deal		
	Examin	er	Shady Grove Adventist Hos		Rockvill			Montgome		
	Funeral Director		5. Social Security Number 6. Sex 7. 1 M № 2 F	Age (In yrs. last birthda)  89 Yrs.	y) If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, )	year) 9. Bird 1918 New	hplace (State or Foreign nuntry) York	
	land bw It		Usual Residence of Decedent           10a. State         10b. County	10c. City, Town or I	Location				10d. Inside City Limits	
	a-f sh	ctor	Florida Broward	Pembroke	Pines				1 <b>X</b> Yes 2 □ No	
	or 284	Director	10e. Street and Number		10f. Zip Code		109	g. Citizen of What Co	•	
	s 23a		12601 So. W. 13th Street					United St		
036	be filed within 72 hours after death with the Maryland ital Hygiene. A other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decede Armed Force 1 Was Decede Armed Force 1 Was Decede Armed Force 1 Was Decede Armed Force 1 Key September 1 Force Armed Force 1 Yes 2 Vear or Date	□ No I	If Yes, specify Cuba	lispanic Origin? (Speci an, Mexican, Puerto Ri Specify:	ry Yes or No- can, etc.)	Black, Whit		
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	shoul and M s marl	ř	19a. Informant's Name/Relationship (Type. Print)			and Number or Rural i				
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baitimore,	permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 Is marked any injury or other traumatic evonce.		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from St.	ale i	position (Name of rematory or other place	1	14,	0c. Location - City or	,	
	artmer artmer ortant: injury		4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee		alom Cemeter	<u> </u>		orwalk, Con		
n	Dep Imp any onc		Milliam A. tomplues	MO1173	Robert A. P 7557 Wiscon	umphrey rune: sin Avenue,	ral Home, Bethesda	, Maryland	nevy Chase, Ind 20814	
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o n	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant 1□Live birt		B Ectopic pregnancy	<i>y</i>		23d. Date of de Month	livery Day Year	
j.	the de	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Fregnar 9 ☐ Unknown 9 ☐ Unknown		5□Other (specify) _					
Ľ	requires that the een signed by th hould be detache	by Pr	Part II. Other significant conditions contributing to dear		underlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?	
ecords,	equire sen sig ould b	ted k	Myelodysplastic Syndram	e			1 □ Yes	2 □ No 3 □ P	robably 4 🖭 Unknown	
Š	e law r has be e 2 sh	Completed	Prostate Cancer				24a. Was an autopsy	prior to	utopsy findings available completion of cause of	
T o	n: The ficate har r, page		25. Was case referred to medical					III Yes	2 No	
OF VITAL Physician: 1	ysicia s certi directo	o Be	examiner? Hospital:	oatient 2 ☐ ER/Outpati	ent 3 DOA Oth	26. Place of Death ( er: 4 ☐ Nursing Home		nce 6 □Other (Spe	cify)	
10 L	<b>6</b> 6	n: T	27. Manager of Death 28a. Date of		of 28c. Injur			v injury occurred		
VISION	Attending r death. ector: After by the funer	catic	2 Accident investigation			Yes 2□No				
<u> </u>	l or At after d Direc J in by	Certification:	4 Homicide determined 28e. Place of building	f injury - At home, farm, s j, etc. <i>(Sp</i> ec <i>ify)</i>	street, factory, office	28	f. Location (Stre City or Town,	eet and Number or R State)	ural Houte Number,	
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the base and manne	is of examination and/or	ath occurred at the ti	me, date and place, an opinion, death occurred	nd due to the car d at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. Licens	e number	29	d. Date signed (Mon	th, Day, Year)	
1	,		MO		Do	064560	/	March 12"	1008	
1	2+1		30. Name and address of person who completed cause		e, Print) I cel Cert	2064560 er Drive	Rat	mill- Mr	20850	
1	Sta	to		gistrar's Signature	vicen cen	a Brive	1 rock	ruc, ru		

DHMH 17 Rev 1/2001

Registrar

MAR 1 4 2008

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- For State amend #1 Per Phy G877 3/17/0 Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARCH 20Ó8 01:30AM Ruth Teresa Yankevich Ruth M. Yankovich /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 8. Date of Birth **Funeral** Days Hours 1 □ M 2 🗙 F 11/20/1914 238-28-1253 93 North Carolina Director Usual Residence of Decedent hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at MD Baltimore 1 ☐ Yes 2 No Towson Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1205 Windy Gate Road 21286 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. Specify: White Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumast. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Ernest H. Morton, Sr. Yates Coggin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2520 McComas Road White Hall, Maryland 21161 Charles Yankovich / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 3/15/2008 Dulanev Vallev Mem. Timonium, Marvland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204 21. Signature of Funeral Service License Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial **Physician** /Medical Due to ( as a consequence of): **Examiner** Sequentially list conditions, if any, hading to mind a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be execu attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Sevore 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manper of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 30. Name and address of pers of who completed cause of death (Item 23a) (Type, Print) Suite 550 Towson N-Charles Gosnell 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#19aperFH3-12-08, EMW, MoCo Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Niloofar Aj Feb 26, 2008 3:05 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center for Hospice Care Towson Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Director June 22, 1966 Iran Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ms 23a or 28a-f shor r must be notified a **Director** New South 1 ☐ Yes 2 No Sydney, Australia Vales Tue. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Wanaaring Terrace, Glenwood Funeral Australia 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 21 Ño Specify: þ Specify: White 3 Widowed 4 Divorced "natural" Completed er than "natur the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ulth and Mental Hygiene. 27 is marked other than ' r traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Hair Dresser Hair Salon 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jalal Aj Allieh Anvary 19a Informant's Name/Relationship (Type. Print) Jalaleddin Sardai - Spouse Sardari - Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Wanaaring Terrace, Glenwood, NSW, Sydney, Australia 27 item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 2-28-2008 Į, permit. Pages Department of Important: If it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Columbia Memorial Park Clarksville, MD 21. Signature of Funeral Service Lic 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 én 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ear /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for an a pyringer warns off. Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the attending pl IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed 2 1No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

24 hours after death Funeral Director: filled in by within 24 hor To the Fune completely fi 2

> State Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year)

A.R.lay

29b. Signature and title of certifier

03 MAR 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 BMC 32 Registrar's Signature

6701

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

25205

Chilo St. Balto. M1 2120x

29d. Date signed (Month, Day, Year)
February 26, 2008

			1- State of Maryland / Dep Registrar Ce	artment of Health and M ertificate of Death	, ,	iene g. No.20	0.8	08393				
8	Physici		1. Decedent's Name (First, Middle, Last) Regina P. Adams		2. Date of Death Month 2/28/		Year	3. Time of Death				
	/Medio		4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of Death Annapolis	2/20/	4c. County		1				
7. 12.	Funeral Director	E Mis	5. Social Security Number 218-16-2149  6. Sex 1 □ M 2 ☒ F  85 Yrs.	8. Date of Birth (Month, Day, 2/15/1	Anne		lace (State or Foreign					
	D	_	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L		2/13/1	923		0d. Inside City Limits				
	the Ma 28a-f s notifie	Funeral Director	MD Anne Arundel Edgewar	10f. Zip Code	10	Og. Citizen of V	Vhat Coun	1 ☐ Yes XX No				
	ath with 23a or ust be	ral Di	335 Colony Point Place	21037		USA						
036	be filed within 72 hours after death with the Maryland ntal Hygiene. so other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)		Americ k, White,					
15-0036	in 72 ho "natur ledical	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Dece	16b. Kind of Bu	siness/Inc	lustry						
717	filed within 72 h Hygiene. other than "natuent, the Medical	Com	12 College (1-4or 5+)	kind of work done during most of worki DO NOT use retired)  Secretary				Foods				
and	uld be fill fental H rked oth	Be	17. Father's Name ( <i>First, Middle, Last</i> )  Paul Lloyd	18. Mother's Name		faiden Surnam	e)					
Mary	12 shouth and Notes in and Notes in and Notes in and Internal	To		ng Address (Street and Number or Rura Forest Green Ct.		,		Code)				
ore,	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once.		20a. Method of Disposition  1 ☐ Burial 2★Cremation 3 ☐ Removal from State  20b. Place of Disposition cemetery, creen	matory or other place)		20c. Location -	City or To	wn, State				
Baltimor	nit. Par artmen ortant: Injury		4 □ Donation 5 □ Other (Specify) Metro Cre	ematory 3/4/2 2. Name and Address of Facility Har		altimor neral F						
ă	Imp Imp any		Josep Al	12 Ridgely Ave. An	nnapolis	, MD 21	50					
	Physician /Medical Examiner	66. /	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b. Cannum A Acquire.									
, 20,	icate be executed physician and s the burial-transit	I Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of).									
00/00	tificate t g physia as the t	edical	d									
C. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/M		□Ectopic pregnancy □ Other (specify)		23d. Date Mor	e of delive nth	ry Day Year				
Cords, P.	equires that isen signed by ould be detail		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba		_	e cause of death? ably 4 □Unknown				
מים ופו	n: The law r fficate has be or, page 2 sh		25. Was case referred to medical			ped? d	Vere autor rior to con leath? ☐ Yes	osy findings available npletion of cause of 2 12 No				
>	nysicia nis certi directo	To Be	examiner?  1 Yes 2 Ho Hospital: 1 Impatient 2 ER/Outpatien	26. Place of Death  ont 3 □ DOA Other: 4 □ Nursing Hor	<i>(Check only one</i> ne 5 ☐ Resider		er (Specify	·)				
5	ding PI h. After th funeral		27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  28b. Time of Injury  2 Accident investigation		28d. Describe hov							
	s after deat s after deat al Director: ed in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, str building, etc. (Specify)		28f. Location (Stre City or Town,		er or Rura	Route Number,				
	he Hospit in 24 hour he Funera pletely fills	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, a westigation, in my opinion, death occurr	and due to the ca ed at the time, da	use(s) and ma ite and place, a	nner as st	ated. the cause(s)				
	To t To t	Ž	29b. Signature and title of certifier	29c. License number	29	d. Date signed						
	S	-	30. Name and address of person who completed cause of death (Item 23a) (Type,	M00057635	7.	15 1	8,	21401				
	Sta	0	Tim Wocks ZOO) medicin  31. Date filed (Month, Day, Year)  32. Registrar's Signature	1 Carking G	Mrag.	Ii, M	10	21401				
	Registra		FEB 2 9 2008	We .								

**Physician** /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician** /Medical Examiner

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

Please	Type or Pri					-		_	ble.		
1 - For State Registrar	State of M	laryland / [		artment of F rtificate of		Mental Hy	gien Reg. N		0.0	000	101
1. Decedent's Name (First, Middle, Last)  Edward William Andrew, Sr.  2. Date of Death Month February										3. Time of L 0148	reath M
4a. Facility Name (If not institution, gi Carroll Hospital		)			r Location of Death Minster	1	4		of Death arrol	L1	
217-28-6519	Sex 7.A	ge (In yrs. last bir 75	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Apr 18	th ay, Year	932	Cour	place (State or ntry) Land	Foreign
Usual Residence of Decedent  10a. State  10b. County  Maryland  Carro	oll	10c. City, Town	n or Lo		neytown				1	10d. Inside City	
10e. Street and Number 33 Fairview Avenu	ie			10f. Zip Code	21787		10g. C		What Cour	ntry?	
11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2 [ If Yes, Give Year or Dates	?	'	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	)-	14. Rac	ce - Americ ck, White,	etc.	
15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	Education rade completed) College (1-4or	5.1)	(Give life. L	kind of work done DO NOT use retired	ent's Usual Occupation ind of work done during most of working O NOT use retired)  Eacturer/Installer  Burial Vault Co.						
17. Father's Name (First, Middle, Las Clarence Andre	,			· · · · ·	18. Mother's Nam Edit	ne (First, Middle h Alexa			ne)		
19a. Informant's Name/Relationship (Type. Print)  Carrie M. Andrew, wife  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  33 Fairview Avenue, Taneytown, MD 21787											
20a. Method of Disposition  1 X Burial 2 □ Cremation 3 ( 4 □ Donation 5 □ Other (Spec		cemeter	ry, cren ty	sition <i>(Name of</i> matory or other place Lutheran	Cem 3/1/		Tá	aneyt	City or To	MD	
21. Signature of Funeral Service Lice	Subo		1	36 E. Ba	ss of Facility My Ltimore S	ers-Dur St, Tane	bora ytov	aw Fu wn, N	mera D 21	1 Home 787	
23a. Pand. Enter the disease, or construct, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. LUNG	d the death. Do r line.  MASS s a consequence of	4	PRESUM	1	or respiratory a		2 ANO	CER	Approximate Interval Betwee Onset and De	en eath
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bDue to (or a	s a consequence o	of):								
that initiated events resulting in death) Last	Due to (or a	s a consequence of	of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)									te of delive	*	ear
Part II. Other significant conditions	contributing to death	but not resulting in	the ur	nderlying cause giv	en in Part I.	23e. Did 1				ne cause of dea	
HTN						24a. Was auto perfo	psy ormed?		death?	psy findings av mpletion of cau	ailable use of
25. Was case referred to medical					26. Place of Dea	1  Yes th (Check only o	2 🛂 🐧 one)	lo	1 🗌 Yes	2 No	

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Furneral Directors. After this certificate has been signed by the attending physician and completely filled in by the furneral director, page 2 should be deteched for use as the burlar-transit Division or Vital Records, P.O. Box 68760,

Completed by Physician/Medical Examiner

Be

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

Certification: To

Medical

State Registrar

WJL 4+IVA

Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 10 No 28b. Time of Injury

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

and manner stated.

M-D.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the date of the pasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

20054580

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Steet # D, Taneytown MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
WASIM FAKIHAR, M. D, 417 E Saltimure

31. Date filed (Month, Day, Year) 32. Registrar's Signature

2008

		ı	For State Registrar	State of Mar	yland / [		rtment of Hertificate of L		Mental Hy	giene Reg. No		0000	
			1. Decedent's Name (First, Middle, Las	1)					2. Date of De	eath	2000	3. Time of Beath	
	Physicia /Medic		JUDY DIANE BEDOR  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of De										
	Examin	er	4a. Facility Name (If not institution, give FREDERICK MEMORI	. County of Death REDERICK									
,	Funeral		Social Security Number     6. Se	,	In yrs. last bir	thday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours   Min.	8. Date of Bi	rth av. Year)	9. Birth	place (State or Foreign	
	Director		220-58-3302	□M 2 <b>X</b> F 5	5	Yrs.	Wionitis Days	Tiours Will.	May 29			*/	
	land ow III		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Tow	n or Lo	cation					10d. Inside City Limits	
	a-f sh	ctor	Maryland Frederick	:	Frede	ric	k					1 XYes 2 No	
	or 28	Dire	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What Cou	ntry?	
	eath w	eral	709 Motter Avenue	12. Was Decedent Ev	or in II S	12.1	2170		nacity Vac or N		USA 14. Race - Ameri	can Indian	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examiner must be notified at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ★ Married	Armed Forces?  1 ☐ Yes 2√ No If Yes, Give	ei iii 0.3.		Vas Decedent of His f Yes, specity Cuba		o Rican, etc.)		Black, White,		
Š	ours a	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give** Year or Dates:		1	I □ Yes 2 No	Specify:			Specify: W	hite	
5	"natu	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a.	Give	lent's Usual Occupa kind of work done d DO NOT use retired)	ition uring most of wor	king	16b. K	ind of Business/Ir	ndustry	
7	within jene.	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)			r/Operato			C	leaning	Service	
2	al Hyg I other	Be C	17. Father's Name (First, Middle, Last)		'			18. Mother's Nan	ne (First, Middle	, Maiden	Surname)		
N N	ould b Ment narked	은			nglebe:			F1ore			Bagent		
2	d 2 sh th and 7 Is n traun		19a. Informant's Name/Relationship (7) John A. Bedor/Husb		1		g Address (Street a Motter A					o Code)	
נֿ	s 1 an f Heal Item 2 other	-4	20a. Method of Disposition		20b. Place of	Dispo	sition (Name of natory or other place	1	Date		ocation - City or T	own, State	
2	Page nent o ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify		Union	Cha	apel Cem.	3/7/	2008	Lib	ertytown	, MD	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amyortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any fijury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens	ral Home									
	407.60	- 4	23a, Varti, Ellier the disea comp	lications that caused th	e death. Do		521 Oposst				ick, MD		
	Physician	l d	23a. art1. Emer the disea comp s ock, or heart failure. List only o Immediate Cause (Final	one cause on each line.	60			,,			11	Approximate interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	Due to (or as a	consequence	of):				_			
	Examiner	_	Sequentially list conditions,	b									
	ted nsit	nine	Bequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.										
5	execu in and ial-tra	Examiner	Due to (or as a consequence of):										
	icate be executed physician and s the burial-transit	dical	(	d									
Š	sertifica ding pl		IF FEMALE:	23c. If yes, outcome pf	nrean anov								
2	Attending Physiclan: The law requires that the death certific roteath.  roteath. After this certificate has been signed by the attending put the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tir	Fetal death		Ectopic pregnancy Other (specify)				23d. Date of deliv Month	ery Day Year	
į	w requires that the de been signed by the should be detached	hysi	1 Uyes 2 No 9 Unknown										
Ď.	res tha igned be de	by P	Part II. Other significant conditions co	ontributing to death but	not resulting ir	the ur	nderlying cause give	n in Part I.				the cause of death?	
5	requi	eted								Yes 2			
	he law e has l	Completed							24a. Was auto perf		prior to co	opsy findings available ompletion of cause of	
2	an: T tificate tor, pa	Be Co	25. Was case referred to medical					26. Place of Dea			1 ☐ Yes	2 □ No	
>	hysiclan: The law his certificate has t I director, page 2 s	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1   Inpatient	2 ER/Ou	tpatien	t 3 DOA Othe				6 □Other (Speci	fy)	
=	ling P.		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day )	/ear) 28b.	Time of njury	Work		28d. Describe	how inju	ry occurred		
	Attenc death cctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury	- At home, fa	rm, stre		fes 2 □ No	28f. Location	(Street ar	nd Number or Rur	al Route Number.	
Š	s after at Dire	Certification:	4 ☐ Homicide determined	building, etc.	(Specity)				City or To	wn, State	e)		
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di		(Check only 2 Medical Exam	sician: To the best of iner: On the basis of e	xamination an	e, death d/or inv	occurred at the time vestigation, in my op	e, date and place pinion, death occu	e, and due to the	e cause(s	and manner as	stated. to the cause(s)	
	o the lithin 2 o the lomplet	Medical	one) 29b. Signature and title of certifier	and manner state	d.		29c. License	number		29d. Da	ite signed (Month)	Dav. Year)	
	F ≯ F ŏ		* Laki nova	2 ME	<del>\</del>						3/03/0	. ,	
	5		30. Name and address of person who co		th (Item 23a)	(Type, I		5443			1 - 5/ -		
	J		Elena Iarikova			th	Street, F	redericl	, MD 21	1701			
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 4 21	32. Registrar	s Signature	13	rock!						
				A. 50 m.		6 1							

			For State	State	of Marylar			lealth and N	/lental Hyg	giene	000	00/	205	
		-	Registrar  1. Decedent's Name (First, Middle,	(act)		Cer	tificate of	Death	2. Date of Dea	Reg. No.	UUU	UU	175	
	Physici		Margaret	,	Bircher				Month Feburar	Day	Year 2008	3. Time of I	Death A <sup>M</sup>	
	/Medic		4a. Facility Name (If not institution,		4b. City, Town, or	r Location of Death	rebutat		unty of Death	1:04				
Par S			6105 Spring Mea	dow Lane	2		Frede	rick			Frede	rick		
F	uneral		Social Security Number	6. Sex 1 □ M 2 F	7. Age (In yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day Dec . 11	Year)		lace (State or	Foreign	
D	irector		Usual Residence of Decedent	10 M 261	94	Yrs.			Dec. 11	, 191	3 Penns	sylvani	.a	
yland	at		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					Od. Inside City	y Limits	
e Mar	a-f st	ctor	Maryland Fred	erick			Frederic	k				1 ☐ Yes	2 <b>N</b> 0	
ith th	or 28	Director	10e. Street and Number				10f. Zip Code			-	of What Cou	•		
ath w	s 23a nust l	rai	6105 Spring Mea					21701			ited St			
5-JUJ36 72 hours after death with the Maryland	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marrie 3 □ ▼Widowed 4 □ Divorced	Armed F	2 ŽNo iive	1	Vas Decedent of H fYes, specify Cuba □Yes ※I□ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, pecify: W			
2 Po Po Po Po Po Po Po Po Po Po Po Po Po	natur Iical I	ted	15. Decedent's (Specify only highest	Education	"	16a. Deced	ent's Usual Occup	ation	ring	16b. Kind	of Business/In	dustry		
ig g	han " e Mec	Completed	Elementary/Secondary (0-12)		(1-4or 5+)			during most of work d)	ung		•	**		
iled w	nt, th	S	12 17. Father's Name ( <i>First, Middle, Le</i>	act)		<u> </u>	lomemaker	18. Mother's Nam	a /Eint Middle	Maidan Ou		Home		
VIANG buld be file Mental Hy	c eve	o Be	Richard Seed	131)					garet Mc		mame)			
shoul	marl	은	19a. Informant's Name/Relationship			19b. Mailin	g Address (Street a	and Number or Rui			own, State, Zic	Code)	-	
, Ma and 2 sl	n 27 is er tra		Margaret Waclaw	sky/ dau	ghter	6105	Spring M	eadow Lar	ne, Fred	erick	, MD 21	1702		
ore,	If item or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3	∃ ∏Bemoval from	20b. I	Place of Dispos cemetery, cren	sition (Name of natory or other place			20c. Locati	ion - City or To	own, State		
Saltimor  ermit, Pages  bepartment of	tant: Jury o	l i	4 Donation 5 Dother (Spe	ecify)	S		Cremato		7/2008		erick,	2	.nd	
permii Debar	any Ir	k. 49	21. Signature of Funeral Service Li	Say	Her	91		ssumtown		reder				
		23a. Part1. Enter the disease, or complications the baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition											veen	
	sician edical		Immediate Cause (Final disease or condition resulting in death)	o			cance	6 ~				Onset and D	2 Ca -	
	miner		(	Due to	o (or as a conseq	quence of):						•		
	Age .	ē	Sequentially list conditions, if any, leading to immediate	b Due to	-									
cuted	nd ransit	Examiner	Cause (Disease or injury that initiated events	C.										
cate be executed	physician and s the burial-transit	Ex	resulting in death) Last  Due to (or as a consequence of):											
cate be ex	ohysic the b	dical		d										
To the Hospital or Attending Physician: The law requires that the death certification within 24 hours after death.	certificate has been signed by the attending prector, page 2 should be detached for use as	Physician/Me									Date of delive	*	ear	
that th	ed by detac		Part II. Other significant condition	s contributing to	death but not res	ulting in the un	derlying cause give	en in Part I.	23e. Did tol	bacco use	contribute to the	ontribute to the cause of death?		
v requires t	en sign	ted by	Cardion		1 .				1 □ Y	_		ably 4 □Ur	- 1	
The law r	ate has be page 2 sh	Completed					<u></u>		24a. Was a autops perfore 1∐ Yes		4b. Were auto prior to condeath?	npletion of car	vailable use of	
VILC	ector,	Be	25. Was case referred to medical examiner?	Hospital:			046-	26. Place of Deat						
P g	r this	. To	1 Yes 2 No	28a. Date	Inpatient 2	ER/Outpatient 28b. Time of		4 Li Nursing no	me 5 Reside			y)		
ding.	: Afte	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	(Mor	nth, Day Year)	Injury	28c. Injun Work M 1□	Yes 2 □ No	260. Describe in	ow injury oc	currea			
Atter	ector by the	ifica	3 ☐ Suicide 6 ☐ Could not determine	20e, Place	e of injury - At ho ling, etc. (Specif	ome, farm, stre	et, factory, office		28f. Location (St	reet and N	umber or Rura	l Route Numb	ver,	
talor rs affe	ed in	Certification:			illig, etc. (Specif	y) 			City or Tòwi	i, State)				
ne Hospi 124 houi	To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier 1 ☐ Certifying (Check only one) 1 ☐ Medical Ex	caminer: On the b	e best of my kno casis of examina nner stated.	owledge, death ation and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and late and pla	d manner as s ace, and due to	ated. the cause(s)		
To th withii	To t	Ĭ	29b. Signature and title of certifier				29c. License				gned (Month,			
			Jours!	iasle	beno	Em.	0.	24887		2/	28/0	8		
4				no completed cause			rint)							
	Sta Registra	A	31. Date filed (Month, Day, Year)  MAR 0 4	2008	egistrar's Signa	ture	sele							

		4	Please	Type or Print in I State of Marylar	nd / Depa	artment of I	Health and N			•	00007
		1	Registrar  Decedent's Name (First, Middle, Las	*f)	Cei	rtificate of	Death	2. Date of De	Reg. No.	2000	3. Time of Death
	siciar	1		,	OOMFIEI	ŢD.		Month March	Day	Year 2008	7:39 A <sup>M</sup>
	edica mine		a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death			County of Death	
			FREDERICK MEMOR	IAL HOSPITAL		FREDI				FREDERI	CK
Funer Direct			219-03-1990	ex 7. Age ( <i>In yrs.</i>	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Aug.	th 8 y	1.920 9. Birth	nplace (State or Foreign MD
land ow			Sual Residence of Decedent  Oa. State 10b. County	10c. Ci	ity, Town or Lo	cation					10d. Inside City Limits
Mary a-fsh ified	į	Į	MD Frede	erick		Frederi	ick				1 X Yes 2 ☐ No
th with the 23a or 28 ist be not	Cingaral Dispositor	1	0e. Street and Number 7112 Autumn Le	eaf Lane		10f. Zip Code 21	.702		10g. Citi	zen of What Col	untry?
paritificate, IMaryliating Z.I.Z.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	N. Filbo	1 In L for	Marital Status     Never Married	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2X No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	)-	14. Race - Amer Black, White Specify: W	
72 hour	Potologo	מופת	15. Decedent's Ed	ucation	16a. Deced	dent's Usual Occu kind of work done	pation during most of worked)	king	16b. Ki	nd of Business/I	
within within than "	1	-	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire memaker			017	n home	
filled v Hygic sther t	2	3 — 1	7. Father's Name (First, Middle, Last)		110	шешакет	18. Mother's Nam	e (First, Middle			
Id be filk ental H ked oth ic eveni	9	2	Seymour W. Hu	iddleston				Ann Wr		,	
and 2 should and 2 should lealth and Men n 27 is marke let traumatic		1	19a. Informant's Name/Relationship (7 Charles Robert		19b. Mailir (Husba	ng Address (Street	t and Number or Aut  Autumn	ral Route Numb	er, City o	r Town, State, Z	ip Code) 21702 rick, MD
Pages 1 and Height Hein		2	Oa. Method of Disposition  1 ★ Buria 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	cemetery, crer	sition (Name of matory or other pla	Cem. 3/4	Date / 2008		cation - City or T	
partification permit. Pages Department of Important: If It any injury or or	ouce.	2	21. Signature of Fundral Service Licen	<u>′</u>	Ď	Name and Addr	ss of Facility Thomp	son Fu	ner	al Home	<u>^</u> e
		1	2 Part1. Enter the riseas , or comp hock, of heart failure. List only	cations that caused the dea			ain St., ing, such as cardiac			wn, MD	21769 Approximate Interval Between
Physicia	_		whock, of heart failure. List only mmedia. Suse (Final disease or condition esulting in death)	the ause on each line.		1 evmoni					Interval Between Onset and Death
/Medic Examin	_			Due to (or as a consec	quence of):						
ited nsit	Evaminar	in or	Sequentially list conditions, any, leading to immediate ause. Enter Underlying	Due to (or as a consec	quence of):						
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oo de tificate tificate as the as the	ipa			.α							
The law requires that the death certificate are has been signed by the attending phys page 2 should be detached for use as the	Dhysician/Madical		F FEMALE:  3b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of o 9 □ Unknown	al death 3	Ectopic pregnanc Other <i>(specify)</i>	zy		2	23d. Date of deli Month	very Day Year
s that the ned by e detac	h/ Dh		art II. Other significant conditions of	ontributing to death but not res	sulting in the u	nderlying cause gi	ven in Part I.	23e. Did t	obacco u	se contribute to	the cause of death?
w requires to be a signer should be		-						10	Yes 2[	□ No 3 □ Pro	obably 4 Unknown
The law cate has b page 2 sl	Completed	-						24a. Was autoj perfo 1 Yes		death?	topsy findings available ompletion of cause of
sician certifi	a	1	<ol> <li>Was case referred to medical examiner?</li> <li>1 ☐ Yes 2 ☑ No</li> </ol>	Hospital: 1 ☑ Inpatient 2 □	TER/Outnotion	oti	26. Place of Deal				
ding Phy h. After this funeral di	in oil	-	7. Manner of Death  1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Inju	4 Li Nursing Ho	ome 5∐ Resi 28d. Describe		Other (Spectory occurred	ify)
To the Hospital or Attending Physician: The law requiviting 24 hours after death.  To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should	Certification.		3 Suicide 6 Could not be 4 Homicide determined		nome, farm, str ify)		-	28f. Location ( City or Tou	Street and wn, State	d Number or Ru )	ral Route Number,
e Hospita 24 hours e Funera letely fille	Medical		29a. Certifier (Check only one) 1. Secretifying Physics 2. Medical Example 1. Secretifying Physics 1.	ysician: To the best of my known inter: On the basis of examinating and manner stated.	owledge, death ation and/or in	n occurred at the t vestigation, in my	ime, date and place, opinion, death occur	, and due to the rred at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
To th within To th	N	2	9b. Signature and title of certifier	0 11		29c. Licens	7		29d. Dat	e signed (Month	, Day, Year)
			La Host	( went,	M	200	52950		3	3-1-20	08
12				Smith 400 W	. Seve	Print) enth St	., Frede	erick,	MD	21701	
	State istrar		1. Date filed (Month, Day, Year) MAR 0 3 20	32 Registrar's Sign							

State Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician**  $p_{\mathsf{M}}$ 02/27/2008 Mark Andrew Branch 4:01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Spring If Under 24 Hrs. Holy Cross Hospital Silver Montgomery Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1⊠M 2□F Director 579-64-0787 02/23/1947 <u>Japan</u> Usual Residence of Decedent death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a, State 10b. County 10d. Inside City Limits 1 X Yes 2 ☐ No Director Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 2 iner must be n 2315 North Capital Street, N.E. 20001 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Micdical Examiner once. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Draftsman Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) Be ဥ Unknown Helen Branch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michael Godwin/Friend 3800 Hillcrest Drive Hollwood, FL 33021 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Lincoln Crematory 3/7/08 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Jorga Mm as Ville lone 3401 Bladensburg Road Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pneumonia /Medical Due to (or as a consequence of): Examiner Upper Gastrointestional Bleeding Sequentially list conditions, if any leading to in models cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ie to for as a consequence of Examine The law requires that the death certificate be executed Sepsis and Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical as the attending for use as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. <u></u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has be rector, page 2 s autopsy perform 1 Yes 2 No or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a

To the Funeral I

completely filled Hospital 🛮 🔀 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10065953 25/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road Silver Spring, MD Dr. Adaku Onukogu 20910 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAR 0 4 2008 Registrar

			Ot-t-	Pepartment of Health and Certificate of Death	, ,		~ ^	00000
	125	T	Decedent's Name (First, Middle, Last)		2. Date of Dea	Reg. No.	<del>U 8</del> -	3. Time of Death
В	Physici /Medio		RAY HOWARD BOLEN		FEB	2 <sup>Day</sup> 20	9 <mark>,</mark> 0,8	2:00A M
1	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	th	4c. County of	of Death	
_63	**************************************	Ш	SOUTHERN MARYLAND HOSPITAL  5. Social Security Number   6. Sex   7. Age (In vrs. last birtl)	CLINTON  hday) If Under 1 Year If Under 24 Hrs				EORGES
B	Funeral Director		10MM OFF	rs. Months Days Hours Min		, Year)	Coun	
	e input type		Usual Residence of Decedent		3/10/	20	VEMI	TÜCKY
	arylan show dat	_	10a. State 10b. County 10c. City, Town				10	0d. Inside City Limits
	he Ma Ba-f s	Director	MD PG TEMPI	LE HILLS				Y Yes 2 No
	a or 2			10f. Zip Code	1	0g. Citizen of W	hat Coun	try?
	ns 23	Funeral	3913 BUCK CREEK ROAD  11. Marital Status 12. Was Decedent Ever in U.S.	20748	Specify Ves or No.	USA 14 Bace	- Americ	an Indian,
20	72 hours after death with the Marylar "natural", or items 23a or 28a-f show sdical Examiner must be notified at	교	1 ☐ Never Married 2 ☑ Married  Armed Forces?  1 ☐ Yes 2 ☑ Mo If Yes, Give	13. Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)		, White, e	
2-0036	ours a	d by	3 LI Wildowed 4 LI Divorced Year or Dates:	1 ☐ Yes 2 XNo Specify:		Specify:	BLAC	CK
2	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or tiems 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education 16a. I (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	rking	16b. Kind of Bus	iness/Ind	lustry
7	withir ene. than	dmo	Elementary/Secondary (0-12) College (1-4or 5+)			<b>anien</b> * :		
יי ס	be filled ntal Hygic od other event, the		17. Father's Name (First, Middle, Last)	JTO MECHANIC  18. Mother's Na	me (First, Middle, I	GENERA: Maiden Surname		TORS
/land	should be nd Mental marked o	To Be	WILL BOLEN		B. "unk			
Mary	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship (Type. Print) 19b.	Mailing Address (Street and Number or R	ural Route Number	r, City or Town, S	State, Zip	Code)
e, ĕ	1 and 2 Health em 27 I		MARGIE W. BOLEN/WIFE 391	13 BUCK CREEK RD	. TEMPL	E HILL:	S,MD	20748
			20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of 0 cemetery	Disposition (Name of crematory or other place)	Date	20c. Location - C	City or To	wn, State
altimor	tt. Pa rtmen rtant: njury		4 □ Donation 5 □ Other (Specify) RESURI	RECTION CEM. 3/7		CLINTO		
g D	permit. Pages Department of Important: If ii any Injury or once.		21. Signature of Funeral Service Uscensor  St. Wart	22. Name and Address of Facility S 65.0 ALLENTOWN	TRICKLA RD, CA	ND FUNI MP SPR	ERAL INGS	SERVICES, MD 20748
			23a. Part1. Enter in disease, v emplications that caused the death. Do no shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardia	c or respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)  ACUTE Myo	CARDIAL INFAR	LCTION			Onset and Death
	/Medical Examiner		Due to (or as a consequence of	r):				
44		e	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	1:			_	
	outed ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events c.					
Ď	e execan an an irial-tr		resulting in death) Last  Due to (or as a consequence of	):				
0/00,	cate be executed physician and the burial-transit	dical	d					
Ď K	ertific ling p	Mec	IF FEMALE:					
S C	death certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnancy		23d. Date Mont		ry Day Year
	that the de led by the a detached i	ysic	1 ☐ Yes 2 TWo 9 ☐ Unknown 9 ☐ Unknown	5 Other (specify)		1		1001
	that ned by deta		Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tob	acco use contrib	oute to the	e cause of death?
coras,	quires n sign	d by	DIABETES MALLIATUR		1 □ Ye	es 2∐No 3	B  □ Proba	ably 4 Unknown
5	aw re	Completed	HYPERTEMPIUN		24a. Was ar	n 24b. W	ere autoc	sy findings available
Č	The lav	mo			autops perform	y pri ned? de	ior to com ath?	pletion of cause of 2 <b>D</b> No
2	slcian: The certificate har rector, page	Be	25. Was case referred to medical examiner?	26. Place of Dea	1 Yes 2 ath (Check only one	F-1	∐Yes 2	2 10110
5	hysle this or	2	1 ☐ Yes 25 No Hospital: 1 ☐ Inpatient 2 ☐ BR/Outp	atient 3 DOA Other: 4 Nursing H	lome 5 Reside	nce 6 □Other	(Specify	)
	fing F	ion:	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tin (Month, Day Year)	ury Work?	28d. Describe ho	w injury occurred	t	
2	death death ctor: y the	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of injury. At home farm	M 1 Yes 2 No	206			
2	after after Dire	Certification:	4 Homicide determined 28e. Place of injury - At home, farm building, etc. (Specify)	i, street, lactory, office	28f. Location (Str City or Town	reet and Number , State)	or Hurai	Houte Number,
			29a. Certifier 1 Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place	and due to the ca	ause(s) and man	ner as sta	ated.
	the Hi in 24 the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/one) and manner stated.	or investigation, in my opinion, death occu	irred at the time, da	ate and place, ar	id due to	the cause(s)
	To t To t		29b. Signature and title of certifier  And K Mc Lays Con A.	29c. License number		d. Date signed		Pay, Year)
	SC		30. Name and address of person who completed cause of death (Item 23a) (T)	D50689		2/28/0	3	
	5/1							
T 18	Stat		SUNTHERN MARY LAND HUS PIT 201 31 Date filed (Month, Day, Year) 32. Registrar's Signature	CENTER 7503 SHE	LRATTS R	DCLIN	70~	mD 70735
	Registra		MAR 0 4 2008					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Ņау **Physician** 1850 LLENE DOROTHY BRADSHAW h /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RED HILL LANE Wicomico NANTICOKE Birthplece (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 200-18-9944 1 □ M 2 X F 85 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State 10b. County in than "natural", or leams 23a or 28e-f show the Modical Examiner must be nutified at 1 ☐ Yes 2 No WICOMICC Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21840 203 death 1 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 5 No 1 ☐ Yes 2 🗷 No Specify: Specify: Baltimore, Maryland 21215-0036 KLALK þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CIALWORKER STATE OF PA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other treumatic event 20x8: BRADSHAW BERNARD ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) NANTIKOKE, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State 2008 JUANTICOKE, MID 3 VANTICOKE CEM. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOME PO BOX 61 BIVALEMD 21814 21. Signature of Funeral Service Licenses 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) MG tastatic Non small call Lung Cancy with Liver metastasses **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as the ed by the attending detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Cinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1as autopsy 20 No 1 ☐ Yes 2 No 1 TYes tel or Attending Physician: T. s after death. sl Director: After this certificate 26. Place of Death Check only one Be 25. Was case referred to medical examiner? Other: 4 ☐ Nursing Home 5 ☐ esidence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No ٩ 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide To the Hospitel o within 24 hours at To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number tle of certifier 29b. Signature and X010198

State Registrar 145 E. Carroll St. Sout A-1 Salisbyry MD21801

person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

Jaai Z

2008

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FEB 29

31. Date filed (Month, Day, Year)

			For State State Registrar	te of Maryland		artment <i>rtificate</i>			, ,	giene Reg. No.?	AR	001.01
7. L	DI: -1-1		Decedent's Name (First, Middle, Last)						2. Date of Dea		Year	3. Time of Death
	Physici: /Medic		Laurie Berk						Februar	y 26, 2	8009	10:00 PM
	Examin	er -	4a. Facility Name (If not institution, give street a. 4620 North Park Avenu		ct		own, or Loc yy Cha	cation of Death			y of Death ntgome	rv
	uneral		5. Social Security Number 6. Sex	7. Age (In yrs. In		If Under	1 Year   If	Under 24 Hrs.	8. Date of Birth	h	9. Birthp	lace (State or Foreign
	irector		125-42-9148 <sup>1□ M 20</sup>	<sup>87 F</sup> 57	Yrs.	Months	Days +	Hours Min.	(Month, Day Nov. 12	, 1950	Coun New	York
and	<b>&gt;</b>		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation					1	0d. Inside City Limits
Maryla	f sho	jo	Maryland Montgomery		evy Cl							1 ☑ Yes 2 ☐ No
h the l	r 28a-	Directo	10e. Street and Number		evy or	10f. Zip	Code			10g. Citizen of	What Coun	itry?
th wit	23a o ıst be		4620 North Park Avenu	e, #1206		208	315			Unite	ed Sta	ites
er dea	tems ler m	Funeral	Arm	Decedent Ever in U.S led Forces?	S. 13. \	Was Deced If Yes, spec	ent of Hispa ify Cuban, N	anic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)	. 14. Ra Bla	ce - Americ ick, White,	
hours after	l', or i	by F	If Y	Yes 2 ⊠ No es, Give ror Dates:		1 □ Yes 2	No S	Specify:		Speci	<sup>fy:</sup> Whit	- e
2 hou	atura cal E		15. Decedent's Education		16a. Deced	dent's Usua	l Occupation	n		16b. Kind of E		
<b>6</b> thin 7	an "n Medi	Completed	(Specify only highest grade complete Elementary/Secondary (0-12)  Coll	eted) ege_(1-4or 5+)				ng most of work	aing			
led wi	her th		47 February News (First Middle 1994)	4	Inte	erior			o /First Middle			esign
d be mi	ed off	Be	17. Father's Name ( <i>First, Middle, Last</i> )  Bert Berk					Audre I	e (First, Middle,	Maiden Surna	me)	
If yearld ZIZIS-UUSO should be filed within 72 hours after death with the Maryland	mark	2	19a. Informant's Name/Relationship (Type. Prir	nt)	19b. Mailir	ng Address			ral Route Numbe	er, City or Towr	, State, Zip	Code)
and 2	27 Is		Steven D. Kupferberg/F	ersonal Re	p. 30	30 Un:	iversi	ity Teri	r. N.W.	Washin	gton,	DC 20016
es 1 g	fltem		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal	20b. Pl	ace of Dispo	sition (Nam	ne of		Date	20c. Location		
Dallinor	lant: I		4 □ Donation 5 □ Other (Specify)		t Linc	oln C	remat	ory 3/1	/2008	Brentw	ood,	Maryland
Dan	Department or result and workers register in the man state or 28a-f show mortants if them 27 is marked other than "naturals", or item 27 is marked other than "naturals", or item 27 is marked out any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee						ple Tri		200	.50
1,000			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death					<ul> <li>Rocky or respiratory ar</li> </ul>		D 208	Approximate
Phy	sician		Immediate Course (Final	e on each line. tastatic L								Interval Between Onset and Death
/1V	tedical		reculting in death)	ue to (or as a consequ		incer						l year
Exa	aminer	L	Sequentially list conditions, b									
peq	ısit	Examiner	cause. Enter Underlying	ue to (or as a consequ	ience of):							
execu	n and al-trar	Exan	Cause (Disease or injury that initiated events resulting in death) Last C.	ue to (or as a consequ	ence of):							
oo / ou, ficate be executed	physician and s the burial-transit	edical	d									
ortifica	ng ph		IF FEMALE:									
ath cer	or use	Physician/M	23b. Was decedent pregnant	es, outcome pf pregna Live birth 2 ☐ Fetal	death 3	Ectopic pro				1	ate of delive lonth	ery Day Year
the de	the a	ysic	1 □ Ves 2 ₩ No 4L	Pregnant at time of de Unknown	eath 5L	Other (sp	өсіту)					
law requires that the death certi	been signed by the attending should be detached for use a	by Ph	Part il. Other significant conditions contributin	g to death but not resu	Iting in the u	nderlying ca	ause given i	n Part i.	23e. Did to	obacco use cor	ntribute to th	ne cause of death?
w requires t	en sig								1 🖾 🕽	res 2 □ No	3 Prob	pably 4 □Unknown
la v s	as be 2 sho	Completed						_	24a. Was autop	osy	Were auto	psy findings available mpletion of cause of
The	After this certificate has funeral director, page 2	Com							perfö 1⊟ Yes	rmed? 2X No	death?	2 □ No
VII.d	certific rector,	Be	25. Was case referred to medical examiner?  Hospital				Othor		th (Check only o			
2 g	r this ral dir	- 1º	1 165 241 140	Date of Injury	ER/Outpatier 28b. Time o		8c. injury at Work?		ome 5 🖾 Resid			y)
SION tending	T. Afte e fune	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M		s 2 □No				
VIS r Atte	rector by th	Certification:	3 Suicide 6 Could not be determined 28e.	Place of injury - At ho building, etc. (Specify		eet, factory	, office		28f. Location (S City or Tox		ber or Rura	al Route Number,
ital o	ral Di led in											
To the Hospital or Attending Physician:	To the Funeral Director. After completely filled in by the funeral	Medical	29a. Certifier (Check only one)  1   Certifying Physician: 2   Medical Examiner: Or any one)	To the best of my know the basis of examinat d manner stated.	wiedge, deat tion and/or in	n occurred vestigation,	at the time, , in my opini	date and place ion, death occu	, and due to the rred at the time,	cause(s) and n date and place	nanner as s e, and due to	tated. o the cause(s)
o the	<b>Го the</b>	Мес	296. Signature and title of certifier	\		29c	. License nu	umber		29d. Date sign	ed (Month,	Day, Year)
- 3			Maller	-VUIT			12890			2/2	9/2008	3
10			30. Name and address of person who complete	d cause of death (Item	23a) (Type,						, 200	-
			John Wiseman, M.D.	5410 Conne	cticut	Ave.	#117	, NW, W	ashingt	on, DC	20016	
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 0.3 2008	33. Registrar's Signat	lui e	A a						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Пау Month Vear **Physician** Mabel Irene Conley Barrows February 24, 2008 0330 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 M 2 F 97 May 15, 1910 Director Kansas 579-74-9228 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Washington None 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 20016 U.S.A. 2846 Arizona Terrace N.W. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes AZNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ White 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic more. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Conley Ethel McCue 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2846 Arizona Terrace N.W. Washington D.C. 20016 Leland Barrows / 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Rock Creek Cemetery Feb. 29, 08 Washington D.C.

22. Name and Address of Facility Joseph Gawler's Sons, INC. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave. N.W. Washington D.C. 20016 23a. Part1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis Days /Medical Due to (or as a consequence of): Examiner Acute Renal Failure Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit the death certificate be executed Days Hypernatremia Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical Congestive Heart Failure Days as IF FFMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗷 No 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Failure to thrive Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No Hypoalbuminemia 24a. Was an has page 2 autopsy performed? certificate DEmentia 1X Yes 2 | No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 1X Inpatient Certification: To this funeral c 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Af 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature ar certifie R006/302 February 24, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Atul Rohatgi, MD 8600 Old Georgetown Road Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State MAR 0 3 2008 Registrar

Directo

Be Completed by Funeral

2

Examiner

29b. Signaty

Nourani,

Medical Certification: To Be Completed by Physician/Medical

Physician /Medical Examiner

has been signed by the attending physician and je 2 should be detached for use as the burial-trar

**Physician** /Medical

**Examiner** 

**Funeral** Director

	Please	e Type or Pi						•		•	•
1 _ For State		State of I	Maryland / D	•		f Health of Deatl		lental Hy	•	0000	20102
Registrar  1. Decedent's Name (i	First, Middle, L	ast)	(	Ceru	ilicale (	Deau	1	2. Date of De	Reg. N	0./	3. Time of Death
Elizab		Miller Ba	gg					Month Feb.	D	ay Yea 2008	
4a. Facility Name (If no				4	4b. City, Tow	n, or Location	n of Death	160.		c. County of De	
	an Hosp				Bethe					lontgome	ery
5. Social Security Num		Sex 7. 1 □ M <b>2</b> F	Age (In yrs. last birtl		If Under 1 Ye Months Da		Min.	8. Date of Bi (Month, Da	ay, Year	7) (	sirthplace (State or Foreign Country)
220-48-758 Usual Residence of De			91					Feb. 5	, 19	17	PA
10a. State 10	0b. County		10c. City, Town	or Loca	tion						10d. Inside City Limits
	Montgon	nery	Gaithe	rsbu	-			<del></del>			1 X Yes 2 □ No
10e. Street and Number		11 5 0 1			10f, Zip Coc					itizen of What (	Country?
333 Russe:	II Ave	#504 12. Was Decede	nt Ever in U.S.	13. Wa		877 of Hisnanic C	rigin? (Sn	ecify Yes or No		14. Race - An	nerican Indian,
1 Never Married	1 2  Mamied	Armed Force	s?					ecify Yes or No Rican, etc.)		Black, Wi	
3 <b>∆</b> Widowed 4 [	Divorced	If Yes, Give Year or Date	s:	1 L	Yes 2.2X	No Specif	y:			Specify:	White
15 (Specify	5. Decedent's only highest g	Education grade co <i>mpleted)</i>	16a. I	Deceder Give kir	nt's Usual Oc	cupation one during mo tired)	ost of work	ing	16b. I	Kind of Busines	ss/Industry
Elementary/Seconda	ary (0-12)	College (1-40 5+	r5+)		arian	tirea)				Educati	ion
17. Father's Name (Fin	irst, Middle, La	st)				18. Mot	her's Name	e (First, Middle	, Maide	n Sumame)	
Arthur Ha								Borden			
19a. Informant's Name		,,,								or Town, State	
Thomas (		; 111 - sor						onsvil		Md 2122 ocation - City	
	Cremation 3	☐Removal from Sta	te   20b. Place of   cemetery			!		4/2008		· ·	cch, Va.
21. Signature of Fune	eral Service Lic	Psee R		22. N	Name and Ad	ldress of Fac		_	w1er	's Sons	s, Înc.
23a. Part1. Enter the shock, or heart for	disease, or co	mplications that caus	ed the death. Do no							ington	D.C. 20016  Approximate Interval Between
Immediate Cause (Fin		ly one cause on fact Seps:				,		,			Interval Between Onset and Death
disease or condition resulting in death)	4	_a	as a consequence of	f):	- 14						
Coguentially list condi	itions	Bilate	eral Lower	Ex	tremit	ies -	infe	cted ul	cer	wound	
Sequentially list condition in any, leading to immediate cause. Enter Underlyi Cause (Disease or injuries)	ediate ing	Due to (or	за а сопведиенсе о	<b>)</b> -							
that initiated events resulting in death) Las		C	as a consequence of	٩٠							
	1	500 10 (0)	as a consequence of	/-							
		d									
IF FEMALE: 23b. Was decedent pr in the past 12 mo 1 □ Yes 2 ☑ V 9 □ Unknown	onths?		2 Fetal death at time of death		ctopic pregna other <i>(specif</i> y					23d. Date of d Month	lelivery Day Year
Part II. Other significa	ant conditions	contributing to death	but not resulting in	the unde	erlying cause	given in Par	: I.	23e. Did	tobacco	use contribute	to the cause of death?
Longstandi					,	<b>G</b>		1 🗆	Yes 2	2 □ No 3 □	Probably 4 XUnknown
Peripheral		_						24a. Was	an	24h Were	autonsy findings available
eripherar	Vascur	al Disease	<del>-</del>					auto		death	
25. Was case referred examiner?	to medical	Heenite!			r		ce of Deat	h (Check only			
1 ☐ Yes 2 ☐ No 27. Manner of Death	)	Hospital: 1 K Inpa			3 DOA					6 □Other (Sp	pecify)
1 X Natural 5 2 ☐ Accident	5 Pending investigati	on (Month, I		me of ury		njuryat Work? I∐Yes 2[		28d. Describe	now inju	ary occurred	
3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	28e. Place of	njury - At home, farr etc. <i>(Specify)</i>	n, street	t, factory, offi	ce		28f. Location ( City or To	Street a wn, Sta	nd Number or le)	Rural Route Number,
29a. Certifier 11 (Check only 20 one)	Certifying F	Physician: To the beaminer: On the basis and manner	of examination and	death o	ccurred at th	e time, date a	and place, eath occur	and due to the red at the time	cause( , date ar	s) and manner nd place, and d	as stated. ue to the cause(s)

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 within 24 hours after death.

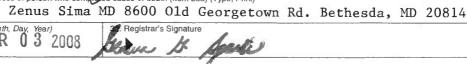
To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:

> State Registrar

31. Date filed (Month, Day, Year) 2008

e and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

0065182

29d. Date signed (Month, Day, Year)

			For State	State of Marylan	,	f Health and Men		0000	00101
	_	-	Registrar  1. Decedent's Name (First, Middle, Las	(t)	Certificate of		Reg. N	io.	3. Time of Death
	Physic		Myrtle L. Bux				Month D	ay ACOS	1/1/0/04
	/Medi Examir		4a. Facility Name (If not institution, give		4b. City, Tow	n, or Location of Death		c. County of Deat	
				inor	Pri	ncess Ann	6	comer	set
	Funeral Director		5. Social Security Number 6. S 371–09–2708	9X 7. Age (In yrs. 91	/ast birthday) If Under 1 Yes. Months Da	ys Hours Min. (	Month, Day, Yea	r) Co	hplace (State or Foreign untry)
	D		Usual Residence of Decedent			104	/02/1916	5 Mic	higan
	arylar ehow	_	10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits 1 X Yes 2 □ No
	the M	Funeral Director	MD Somerse  10e. Street and Number	et Pri	ncess Anne	to.	100.0	Citizen of What Co	
	3a or	DI	11974 Edgehill 1	Terrace		1853	109.0	USA	ortity:
	death	nera	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?		of Hispanic Origin? (Specify Cuban, Mexican, Puerto Rica	Yes or No-	14. Race - Ame	
99	or Ite	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give	1 ☐ Yes 2 🖾		n, etc.)	Black, White	
21215-0036	be filed within 72 hours after death with the Maryland nat Hygiene. ad other then "natural", or Items 23a or 28a-f ehow event, the Medical Examiner must be mailified at	ed by	3 Nidowed 4 □ Divorced  15. Decedent's Ed	Year or Dates:	16a. Decedent's Usual Oc		155	Kind of Business/	nite
75	- 6	Completed	(Specify only highest gra	College (1-4or 5+)		one during most of working	160.	Kind of Business	industry
	filed within Hygiene. other then ont, the Mark	Com	12	none	Homemaker		Ov	n Home	
nd	be file id oth oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (Fir	st, Middle, Maide	in Sumame)	
Maryland	should be filed within and Mental Hygiene.  marked other then umatic event, the M	우	Unknown  19a. Informant's Name/Relationship (	Type Print)	19h Mailing Address (Str	Unknown reet and Number or Rural Ro	uta Numbar City	or Town State	Zin Code)
Ma	ith ar ith ar 27 is r trau		Pamela J. Taylor			Road, Prince	. ,		
Je,	of Hea of Hea fitem: r other		20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐		Place of Disposition (Name of temperatury) and control of the cont	f Date		Location - City or	
ij			4 □ Donation 5 □ Other (Specify	Sal	lisbury Crema	tory 02/29/2	008 Sa1	Lisbury,	Maryland
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Scarce Licen	500	22. Name and Ad Hinman Fi	uneral Home			
-4	22244		a. Part1. Enter the disease, or com	MOO2	295 11673 Son	merset Ave.,	Princess	Anne,	Approximate
	Physician	4	shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	000		menti	,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consect	And the second s	iner de	menci	a	4 grs
	Examiner		Sequentially list conditions, if any, leading to immediate	b					
	nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):				
ď.	execuin and ial-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or as a conseq	uence of):			-	
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Ical	(	d					
9	death certifica attending ph d for use as th	Physician/Med	IF FEMALE:	00-14					
Box	attend for us	clan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1□Live birth 2 □ Feta 4□Pregnant at time of d	I death 3 Ectopic pregna			23d. Date of del Month	ivery Day Year
P.O.	t the de by the a	hysi	1 ☐ Yes 2 🖪 No 9 ☐ Unknown	9☐ Unknown	5 _ 5 ( <i>speen)</i>	/			
	es tha igned I be det	by P	Part II. Other significant conditions of	001	/= 111 1	given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
Records,	w requir been si should	Completed	Cosenfia	e Hyper	feasin		1 🗌 Yes	2. <b>⊠</b> No 3 ☐ Pr	obably 4 Unknown
3ec	e law has b	mple					24a. Was an autopsy performed?	prior to o	topsy findings available completion of cause of
a	ician: The Certificate harector, page	e Co	25. Was case referred to medical				1□Yes 2⊠N		2 No
Vital	Phyaician: r this certificinal director,	To Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ DOA	26. Place of Death /Ch Other: 4 Nursing Home		6 □Other (Soe	control .
J Of	ding Phy h. After thi funeral o		27. Manner of Death	28a. Date of Injury (Month, Day Year)			Describe how inj		Chyj
sioi	uttendir death. ctor: Af y the fu	catic	1 K Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			1 Yes 2 No			
Division	or Att after d Direct I in by I	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, factory, off		ocation (Street a City or Town, Sta		ural Route Number,
_	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	wledge, death occurred at th	e time, date and place, and o	fue to the cause(	(s) and manner as	stated.
	vithin 24   To the Fu	Medical	onej	iner: On the basis of examina and manner stated.	tion and/or investigation, in r	ny opinion, death occurred at	the time, date a	nd place, and due	to the cause(s)
	To Too	Σ	29b. Signature and title of certifier	7 12 11		ense number		ate signed (Monti	
,			Sugar 1	a. Isella	7	29505		02-28	5-08
5	€B		GREGORIO M.			VABERRY DR	SALISE	IRY MD	21801
	Sta		GREGORIO M.  31. Date filed (Month, Day, Year)  MAR 0.3	32. Redistrar's Signa	iture		,		

DHMH 17 Rev 1/2001

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Month BOWLING GEORGE WASHINGTON 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Civista Medical Center 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 → M 2 □ F Months Days Hours Min. NOV.3,1915 MARYLAND 219-12-4961 Usual Residence of Decedent 10a State 10c. City. Town or Location 10d. Inside City Limits 10h County 1 ☐ Yes 2€1No MD CHARLES FAULKNER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20632 9669 BRUNSWICK ROAD U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 ☐ X\o If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) FARMER FARMING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) THOMAS BOWLING MARIE SIMPSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH A. BOWLING/SON 332 OWENSVILLE RD., WEST RIVER, MD 20778 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State BOWLING FARM CEM. 13,2008 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FAULKNER, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. N AVE., LA PLATA, MD20646 LA 5635 WASHINGTON AVE., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final lung Collar disease or condition resulting in death) Due to (or as a consequence of): - 10 des Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Price that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Extreme 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown to IVine 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Year) 5 Pending investigation

P.O. Box 68760. or Vital Records, **Physician** 

/Medical

Examiner

**Funeral** 

Director

show

28a-f

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'natural", or items 23a

and Mental Hygiene.

Item 27 | Health

Department of H Important: If ite any injury or ot

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/Medical

Examiner

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Pages 1 and 2 should be

Baltimore, Maryland 212-0036

Director

Funeral

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Completed

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Certification:

Medical

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

other traumatic event, the Medical Examiner must be notified at

requires that the death certificate be executed The Division To the Hospital or Attending

O,

State Registrar

31. Date filed (Month, Day, Year) 7 2008

29b. Signature and title of certifier

6 ☐ Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician March 2<sup>Year</sup> 8 Catherine Eleanor Correri 09:25 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Citizens Care Center Havre de Grace Harkord If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2CXF 79 Yrs. 218-26-0819 **Director** 30, 1928 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic avant, the Medical Evarniner must be notified at 1 ☐ Yes XXNo Director Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 505 Congress Ave. Apt 310 U.S.A. or Itams 23a 21078 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Year or Dates: natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 12 should be filed within in and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Business Owner Produce Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Steiner Wise, Sr. Anges Whittenington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If itam 27 Is, any injury or other trau <u>oncs</u>. John Correri, Sr. (Son) 1402 Bayview Drive Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Mt. Erin Cemetery 03/05/2008 Havre de Grace, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. 21. Signature of Faneral Service Licens 123 S. Washington St. Havre de Grace. ND 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician elyo V 25 W W /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a contequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed emannin burial-trar Box 68760 Be Completed by Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 D No 24a. Was an autopsy performed? (es 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Plage of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 Yes / 2 No Other: Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: / 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 To tha 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 68 Name and address of person who completed cause of death (Item 23a) (Type, Print) MD6 MIGH 2008 32. Registrar's Signature 31. Date filed (Month, Say Year) State Registrar

			1 - For State Registrar	State of	f Marylar	_	artment rtificate			and M	ental Hyg	giene	108	08407
	Physici /Medio		Decedent's Name (First, Middle, Las Louise Camp								2. Date of Dea Month March		08 Year	3. Time of Death 1:35 A M
	Examir		4a. Facility Name (If not institution, give Lions Rehab Cent		nber)				Location of				unty of Death legany	
	Funeral Director		5. Social Security Number 6. Sec. 211–24–0217	ox □M 2\$(D)AF	7. Age (In yrs. <b>97</b>	last birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min,	8. Date of Birth (Month, Day Jan.	5 <sup>Y</sup> 191	9. Birthp Coun West	lace (State or Foreign Virginia
	Maryland I-f show	tor	10a. State 10b. County Allegan	У	10c. Cit	y, Town or Lo Luke	cation						11	0d. Inside City Limits
	th with the 23e or 28s	al Director	10e. Street and Number 315 Fairview S	t.			10f. Zip 6	Code 2154(	)		1		of What Coun	•
920	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23e or 28a-1 show any injury or other traumatic event, If a Medical Examinar must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Dece Armed For 1 Tes If Yes, Giv Year or Da	ces? 2 [ <b>X</b> No e		Was Decede f Yes, speci		panic Orig , Mexican Specify:	gin? (Spe Puerto f	cify Yes or No- Rican, etc.)		Race - Americ Black, White, e ecify: Whi	etc.
Maryland 21215-0036	d within 72 hogiene. giene. er then "natu If e Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0·12) unknown	ucation de <i>completed)</i> College (1	4or 5+)		tent's Usual kind of work DO NOT use DMEMAK	( done di e retired)	tion uring most	of workir	ng		of Business/Ind	dustry
yland	ould be file Mental Hy arked othe	To Be C	17. Father's Name (First, Middle, Last) Dominick Chuc	ci					18. Mothe Ni		(First, Middle, l Luche (	Maiden Sur Chucc:		
	and 2 shu lealth and m 27 Is m		19a. Informant's Name/Relationship (T Elvira Amoruso/ d			315 F	airvi	ew S	St, L	uke,	Marylar Marylar	nd 2'	1540	
Baltimore,	I. Pages 1 tment of H tant: If ite ijury or ot		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ t  ' 4 ☐ Donation 5 ☐ Other (Specify,		State St.	Place of Disposementary, crem Peter	s cem	eter	У ;	03/08 2008	o/ [	Veste		wn, State Maryland
Ba	permil Depar Impor any in		21. Signature of Funeral Service Licens	e B	nl	11	1 Chu	rch	St.,	West	al Fune: cernport	, Mai		21562
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. End	or as a nseq	de	ment		, such as (	cardiac of	respiratory arm	est,		Approximate Interval Between Onset and Death
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rds, P.	wrequires that the de been signed by the should be detached	þ	Part II. Other significant conditions co	ntributing to dea	ath but not resu	ulting in the un	derlying cau	use giver	in Part I.	_		es 2 🗆 No		a cause of death?
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Division of Vi	hys this	To B	examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5  Pending 2 Accident investigation	28a. Date of		ER/Outpatient 28b. Time of Injury		Other c. Injury a Work?	4 Nur	sing Hom	(Check only onle e 5 ☐ Reside 3d. Describe ho	nce 6 🗆		)
DIVIS	i Sire	Certification:	3 Suicide 6 Could not be determined	buildin	of Injury - At ho g, etc. <i>(Specify</i>	r) 					3f. Location (Sti City or Town	. State)		
	4 5 4 9	Medical	29a. Certifier (Check only one)  1 Certifying Physical Examination (Check only one)  29b. Signature and title of certifier	sicien: To the base ner: On the base and manne	is of examinat	wledge, death ion and/or inve	estigation, ir	the time n my opin	nion, death	place, ar occurred	d at the time, da	ite and plac	ce, and due to	the cause(s)
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		5	30. Name and address of person who co  WONSOCK SHLN  31. Date filed (Month, Day, Year)	MO		ISHOP	WAL	SH,	KD	CUM	IBER LA	ND	MO 2	1502
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			For State Registrar	State of Maryland / Depa	artment of Health and Me rtificate of Death	ntal Hygiene Reg. No.	2008 08408
	Dhualai		1. Decedent's Name (First, Middle, Las			. Date of Death Month Day	3. Time of Death
	Physici /Medio		Wallace Redfie		F	'ebruary	
N. Carlotte	Examin	er	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		County of Death
			St. Catherine's  5. Social Security Number 6. Secur		Emmitsburg  If Under 1 Year   If Under 24 Hrs.   8		rederick
	Funeral Director			X M 2 ☐ F 79 Yrs.	Months Days Hours Min.	. Date of Birth (Month, Day, Year) OV . 7, 19	9. Birthplace (State or Foreign Country) Maryland
	and		10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	Maryl	tor	Maryland Frede	rick Emmits	burg		1∑Yes 2 No
	28a	rec	10e. Street and Number		10f. Zip Code	10g. Citi	zen of What Country?
	3a or		331 South Seto	n Avenue	21727	Uni	ted States
21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If Item 27 is marked other then "naturel", or Itame 23a or 28a-f show any injury or other treumatic event, Ita Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	1 XYes 2 No	Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric	can, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
ŏ	2 hou	ted	15. Decedent's Ed	ucation 16a Dece	dent's Usual Occupation	16b. Kir	nd of Business/Industry
215	hin 7	Completed	(Specify only highest gra	College (1-4or 5+)	kind of work done during most of working DO NOT use retired)	-	
21	filed wit Hygiene other the	Corr	12	Sa	lesman		ect Marketing
pu	be file itel Hy id oth	Be	17. Father's Name (First, Middle, Last)			First, Middle, Maiden	Sumame) (unk.)
yla	should the should the	70	James M. Campbe		Margaret		
Maryland	2 sh and is m		19a. Informant's Name/Relationship (7	Type, Print) 19b. Mailir n/Companion 131 (	ng Address (Street and Number or Rural R		
-	l and lealth in 27 her ti						cation - City or Town, State
Baltimore,	it of h		20a. Method of Disposition 1 ☐ Burial 2 ACremation 3 ☐	memoval from State	reb.	29,	
ţ	t. Pa rtmen rtant:		4 Donation 5 Other (Specify	7	en Crematory 200	-	lerick, Maryland
Bal	permit. Departr Importa eny inju		21. Signature of Funeral Service Licen	RE	sthaven fühleral S 01 Catoctin Mtn.	Services	, Skkot Cody P.A.
1	Physician		Immediate Cause (Final disease or condition	incations that caused the death. Do not entone cause on each line.			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	b. Rul Guar TC 1	d arthuiti	5 '	2044
	nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequencé of):			,
68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	_	resulting in death) Last	Due to (or as a consequence of):			
Box 6	th certific lending p	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy	2	23d. Date of delivery
P.O. E	that the dea ed by the ati detached fo	Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Other (specify)		Month Day Year
	res tha	by P	Part II. Other significant conditions of	ontributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacco u	se contribute to the cause of death?
ord	w require been si should t	ed	Corollarya	Mery dela	ll.	1 Yes 2	No 3 Probably 4 Unknown
Records,	The law re te has be age 2 sh	Completed	Ronal Fire	refficiency		24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 1 Yes 2 1 No
Vital	ician: Th certificate rector, pag	a)	25. Was case referred to medical		26. Place of Death (C		12 100 20110
>	Physici this cer al direc	ToB	examiner? 1 🗆 Yes 2 📉 No	Hospital: 1 Inpatient 2 ER/Outpatien	t 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6	S ☐Other (Specify)
ion of	Attending Ph r death. ector: After th by the funeral		27. Manner of Death t Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		d. Describe how injury	
Division	2 = -	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 28f	f. Location (Street and City or Town, State)	d Number or Rural Route Number, )
	the Hospital ( hin 24 hours at the Funeral D mpletely filled i	Medical C		ysicien: To the best of my knowledge, death niner: On the basis of examination and/or in- and manner stated.			
	To the vithin To the comple	Me	29b. Signature and title of certifier	2 a Direct	29c. License number	29d. Date	e signed (Month, Dey, Year)

HWA

31. Date filed (Month, Day, Year) State Registrar

FEB 2 9 2008

# **Physician** /Medical Examiner **Funeral** Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director Baltimore, Maryland 21215-0036

Please 1	ype or Print in Black Indelible Ink. Ensure Al	l Copies Are Legible
	State of Maryland / Department of Health and M	lental Hygiene
	Certificate of Death	Reg. No.
t, Middle, Last		2. Date of Death

1- State Registrar Certificate of L		Rea		ogtoo
1. Decedent's Name (First, Middle, Last)		Date of Death	2000	3. Time of Death
George Winston Cherry		Month	Day Year 2008	5 46 PM
4a. Facility Name (If not institution, give street and number)  4b. City, Town, or		7	4c. County of Deatl	
Prince George's Hospital Cheverl	1 **			
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs. 8.	Date of Birth	Prince G	pplace (State or Foreign untry)
578-28-3007   11		(Month, Day, Ye	ear) Con	th Carolina
Usual Residence of Decedent		Dr. Zie	1923 NOI	th carolina
10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Maryland   Prince George's   Capitol Heights				1∏ Yes 2 □ No
10e. Street and Number 10f. Zip Code		10g.	Citizen of What Co	untry?
6607 Wilburn Drive 20743		U	nited Sta	tes
11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of His	spanic Origin? (Specify	Yes or No-	14. Race - Amer	ican Indian,
1 Never Married 2 Married   1 M Yes 2 No		iii, eic.)	Black, White	_
3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	Зреспу.		Specify: B	lack
15. Decedent's Education 16a. Decedent's Usual Occupa (Specify only highest grade completed) (Give kind of work done do	uring most of working	168	b. Kind of Business/I	ndustry
Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)				
12 years Post Office Su			Governme	nt
	18. Mother's Name (Fi	rst, Middle, Mai	den Surname)	
Leslie O. Cherry	Rosetta H	endrix		
19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street a.				
Deborah R. Young - Daughter 110 Whistling	g Pine Road	Denton	, MD 2162	9
20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	200	c. Location - City or 1	own, State
1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) . Mt. Arorat Bapt Ch		/2008	Windsor,	N. C.
21. Si) nature of Funer   Service   Cerr co	s of Facility Stewa	rt Fune	ral Home.	Inc.
	ng Road, N			
23a, Part Enter the disease, or complications that caused the death. Do not enter the mode of dying			-	Approximate
shock of near failure. List only one cause on each line.				Interval Between Onset and Death
disease or condition resulting in death)  a. Advanced Cardiomy opathy				5 years
Immediate to use (Final disease or condition resulting in death)  a. Advanced Cardion of athy  Due to (or as a consequence of):  b. Cardina due to (or as a consequence of):  Due to (or as a consequence of):				
Sequentially list conditions, b. Colonary Allery Diseas	۰			10 years
cause. Enter Underlying				
Cause (Disease or injury that initiated events resulting in death) Last  C. Dia bettes Mellitus  Due to (or as a consequence of):				10 year
d. Hypertension				10 years
IF FEMALE:				
23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy			23d. Date of delive	*
1 ☐ Yes 2 ☒ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 9 ☐ Unknown			WOTH	Day Year

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed to the Funeral Director: After this certificate has been signed by the attending physician and Somoletely filled in by the funeral director, page 2 should be detached for use as the burial-transit

within 24 hours after death.

Division or Vital Records, P.O. Box 68760,

Examiner

by Physician/Medical

Be

Certification: To

Medical

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2**⋉**No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one,

Completed 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 5 ☐ Pending investigation 6 Could not be determined 3 Suicide

Hospital: 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

3□ DOA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

20785

28d. Describe how injury occurred

29a. Certifier (Check only one)

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D0012015

Landover.

MD

29d. Date signed (Month, Day, Year) 3-1-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steinb Louis

State Registrar 31. Date filed (Month, Day, Year)
MAR 0 4 2008

**Physician** /Medical Examiner Examiner

attending physician and for use as the burial-trar

signed by

has

To the Hospital or Attending P. within 24 hours after death.
To the Funeral Director: After the completely filled in by the funera

Physician/Medical

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Completed

Be

Certification: To

Medical

State

Box 68760

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IALES, VIVIAN IS 3 Division or Vital Record:

the death certificate be

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show edical Examiner must be notifled at

Item 27 is marked other than "nature other traumatic event, the Medical

Health tem 27 i

permit. Pages
Department of I
Important: If Ite
any injury or or
once.

Director

Funeral

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Completed

Be

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MD

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No

PRIOR HEPARIN INDUCTO THROMBOCYTOPENIA, STROKE

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident

6 □ Could not be 3 ☐ Suicide determined 4 ☐ Homicide

28a. Date of Injury (Month, Day

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated.

29b. Signature and title of certifier

29c. License number 036252 29d. Date signed (Month, Day, Year) MARCH 02, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print), ST, KARIYA, MD, NGOS CONCORD ST, #500, KENSINGTON MD 2089) 31. Date filed (Month, Day, Year)

03 2008



Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AMEND#5perINF 3/7/08, EMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Culberson 6:26 PM WILLE 23 ZDD8 FEBTUAR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AUrel Regional Hospital Prince Georges AUSE 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months ouintry) 1**X** M 2□ F 83 Mississippi Director 5-20-24 425-32-5572 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD 1 Yes 2 No Director 6 LAUrel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 730D U.S.A VAN DUSEN 20707 by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) EXPORT Elementary/Secondary (0-12) College (1-4or 5+) Self- Employed TRANSport 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie Culberson ANNIE M. DANIEL ည 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JZ / STOTHER 10410 BAlswood Ct. LAUrel. AMES WHITFIELD Md. 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Oliver Conetery 108 Washington D.C. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The House of Williams FINERL Service amer Ewellen 814- Upshir Street, N.W. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HITEN DIONARY YCARS /Medical Due to (or as a conse dence of) Examiner Sequentially list conditions, if any, leading to immediate eases. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐ Pregnant at time of death ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? After this certificate has been signed funeral director, page 2 should be def þ ChroNic RENAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Seizure Disorder 2 No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident nin 24 hours after death the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bhojrag.

2008

MD

32 Registrar's Signature

RAIKUMAR 6

31. Date filed (Month, Day, Year)

03

D 23181

704 Goman Ave. #TI LAURA

2008

Md.

	_	1 - Foramend #19a l			Cel	lillicate	UI DeallI			- /	HIB	1114	1 6
Physicia	ın.	1. Decedent's Name (First, Middle							Date of D     Month	eath Day	Year	3. Time o	f Death
/Medica		Paul K. Cha	ing						Februa			10:57	M q
Examine		4a. Facility Name (If not institution	n, give street and n	number)		4b. City, To	wn, or Location	of Death		4c. C	ounty of Deat	th	
		Montgomery Hos	spice-Cas	ev Hous	se	Rock	ville				Mon	ntgomer	y
Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Under 1	Year If Under		8. Date of B	irth	9. Birt	thplace (State	
Director		560-46-7538	1 🙀 M 2 🗆 F	94	Yrs.	Months   E	Days Hours	Min.	April	ay, Year) 8. 191		nuntry)	
		Usual Residence of Decedent							<u> </u>	0, 101	.0		
at w		10a. State 10b. County		10c. 0	City, Town or Lo	ocation						10d. Inside C	ity Limits
fied -f	वं	Maryland	Montgom	nery	Silve	er Spri	ing					1 ☐ Yes	2 <b>X</b> No
noti	Je l	10e. Street and Number				10f. Zip Co	ode			10g. Citize	n of What Co	ountry?	
3a ol		3122 Gracefiel	ld Road,	Apt. 30	2		20904	Į.		Į	JSA		
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status		ecedent Ever in	U.S. 13.	Was Deceder	nt of Hispanic Or Cuban, Mexica	rigin? (Spe	ecify Yes or N	lo- 14	. Race - Ame	rican Indian,	
lter Iner	Ē	1 ☐ Never Married 2 Marr		Forces? s 2 □ No		If Yes, specify	Cuban, Mexica	an, Puerto	Rican, etc.)		Black, White		
f", or	ğ	3 ☐ Widowed 4 ☐ Divorced	If Yes, 0 Year or	s 2 No Give X Dates:		1 ☐ Yes 2	No Specify.	:		S	pecify:	Asian	
alE	정	15. Decedent	t's Education		16a, Dece	dent's Usual (	Occupation			16b. Kind	of Business/	/Industry	
edic edic	et	(Specify only highes	st grade completed	•	i (Give	kind of work o	done durina mos	st of work	ing	1			
than e M	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)			ŕ						
t, t	ပိ	17. Father's Name (First, Middle,	( act)	_5+	P <sub>1</sub>	cofesso		er's Name	- (First, Midd		lucatio	on	
evel evel	æ	Leo Kibin Char	*				Lucia		,	e, maideri Si	urname)		
atc	ပ္												
acm a		19a, Informant's Name/Relations Frances	hip (Type. Print)		19b. Maili	ng Address (S	Street and Numb	er or Rura	al Route Num	ber, City or 1	Town, State, 2	Zip Code)	
er tr		Francis Min Cha	ang/Wife		3	3122 Gr	racefiel	ld Ro	ad, #3	02, Si	lver S	Spring,	MD 2
oth		20a. Method of Disposition		1	. Place of Dispo cemetery, cre-	osition (Name matory or othe	of er place)		rch 3,	20c. Loca	ation - City or	Town, State	
y or		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		m State Ga			Cemeter	ту на	2008	C . 1		adaman M	1
inju		21. Signature of Funeral Service			2:	2. Name and	Address of Facil	lity				ring, M	aryr
any ir		λ _	<	Q			Address of Facil J. Coll						
-		Co Dat Established	1 0	2007		00_Univ	ersity_	Plvd	,-W, S	ilver	Spring	Approxima	
		23a. Part1. Enter le disease, or shock, or he in failure. List	only one cause or	n each line.	atii. Do not en	ter the mode t	or dying, such as	s cardiac (	or respiratory	arrest,		Interval Be	tween
ysician		Immediate Cause (Final disease or condition	Photo: Colored										
edical			CON	test were trance	cular 7	ani der							
		resulting in death)		to (or as a cons		ccider	n.t.						
miner		resulting in death)				Accider	nt						
,	ıer	resulting in death)	Due to		equence of):	Accider	nt.						
	miner	Sequentially list conditions, if any, leading to immediate cause. In any leading to immediate cause (Disease or injury)	Due to	to (or as a conse	equence of):	Accider	nt						
,	Examiner	resulting in death)	b. Due t	to (or as a conse	equence of):	Accider	nt.						
an and rial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Fast Uncoding Cause (Disease or injury that initiated events	b. Due t	to (or as a conse	equence of):	Accider	nt.						
ohysician and the burial-transit	dical	Sequentially list conditions, if any, leading to immediate cause. Fast Uncoding Cause (Disease or injury that initiated events	b. Due t	to (or as a conse	equence of):	Accider	nt.						
ohysician and the burial-transit	dical	Sequentially list conditions, if any, leading to immediate cause. Fast Uncoding Cause (Disease or injury that initiated events	b. Due t c. Due t d.	to (or as a conse	equence of): equence of): equence of):	Accider	nt.						
ohysician and the burial-transit	dical	resulting in death)  Sequentially list conditions, if any, leading to immediate case. List of the case	b. Due t c. Due t d.	to (or as a conse	equence of): equence of): equence of): gnancy stal death 3 [	⊒Ectopic preg	inancy			23	id. Date of del	livery	Year
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	Physici /Medic		1. Decedent's Name (First, Middle, I	Last)	C	OFF	=1~			2. Date of Dea	Day 26	Year <b>O</b> 8	3. Time of Death
	Examin		4a. Facility Name (If not institution, g				- ,		ation of Death			nty of Death	
	Funeral Director		Anne Arundel Me 5. Social Security Number 550-60-8610		ge (In yrs. las	t birthday) Yrs.	If Under 1 Y		Under 24 Hrs. ours Min.	8. Date of Birt (Month, Date 12/1/10	h	Cour	lace (State or Foreign
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5-0036	after or tte	by Funerai	11. Marital Status  1 □ Never Married 2 🌠 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1	?		Was Decedent If Yes, specify 1 ☐ Yes 2 🛣		nic Origin? (Sp. exican, Puerto pecify:	ecify Yes or No- Rican, etc.)	ı	lace - Americ llack, White, cify: Whi	etc.
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Baltimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		cem	etery, crei	esition (Name of matory or other ematory	of rplace)	2/27	08		n-City or To ater,	
Balt	permit. Page Department Important: If any injury o		21. Signature of Funeral Service Lice	ensee						eorge P. id Rd. E			ral Home D 21037
8760,	Physician /Medical Examiner physician and physician and the prival-transit	ai Examiner	23a. Part1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	ine.  Sa consequer  s a consequer  s a consequer	Cen, loce of):	er the mode of	l dying, st	my o	pathy	Test,		Approximate Interval Between Onset and Death 5 0
P.O. Box 687	death certifi e attending I ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	ath 3	Ectopic pregn				1	Date of delive	ery Day Year
	es De d	þ	Part II. Dther significant conditions	contributing to death	but not resulti	ng in the u	nderlying caus	e given in	Part I.	23e. Did to	-		ne cause of death?
Vital Records,	The law ate has b page 2 sl	Completed								24a. Was autop perfo 1 Yes			psy findings available mpletion of cause of 2  No
Κ	Physician: this certific al director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:	ient 2 FB	VOutpatier	nt 3 DOA	Other		n <i>(Check only o</i> me 5 ☐ Resid		Other (Specif	ivl
ion of	ding J. After funei	$\vdash$	27. Manner of Death 1 SNatural 5 Pending 2 Accident investigat	28a. Date of Inj (Month, Da	ury 28	Bb. Time o Injury	28c.	Injury at Work?		28d. Describe h			y)
Division	at or Atte s after de it Directo	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 286. Place of in	njury - At home etc. (Specify)	e, farm, sti	reet, factory, of	fice		28f. Location (5 City or Tox		mber or Rura	al Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edicai C	29a. Certifier (Check only one)  Certifying 2 Medical Exp	Physician: To the best aminer: On the basis and manner s	t of my knowle of examination tated.	edge, deat n and/or in	h occurred at the vestigation, in	ne time, d my opinio	ate and place, n, death occur	and due to the red at the time,	cause(s) and date and plac	manner as s e, and due lo	tated. the cause(s)
	To the within To the comp	W	29b. Signature and title of certifier	Jalen	ta un	)	29c. Li	D cense nu	2143	88	199d. Date sig	ned (Month,	Day, Year)  My 27, 200  MY 27, 200
_	8w		30. Name and address of perso with MILHARL J. LG	PENTA M	death (Item 2:	3a) (Type,	KENSE Brint)	1 H	a HWAY	ANNA	Pous	Mon	V140/
7	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 9 21	108 Regist	trar's Signatur	· do	و نکمه						
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DHMH 17 Rev 1/2001

Division or Vital To the Hospital or Attending Physician: within 24 hours after control the Funeral Director: Af

> EB State Registrar

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR 04

Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, MD 32. Re strar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008



29c. License number

9 48098

29d. Date signed (Month, Day, Year)

12008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-01899 State of Maryland / Department of Health and Mental Hygiene Michael Steven Carey Certificate of Death Reg. No 1- For State Registrar 2. Date of Death Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day March 7, 2008 1010 hrs Medical Examiner tc. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Wicomico Salisbury Route 50 and Queen Avenue If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Hours Min. Months Days Director -253 -96 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Yes 2 No 10g. Citizen of What Country Director 10f. Zip Code 10e. Street and Number 8 0 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Mantal Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) , or items event, the Medical Examiner must be Armed Forces Married Never Married 2 Yes Specify: 2 No specify: 4 X Divorced If Yes, Give Year 3 Widowed 6b. Kind of Business/Industry ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) automotive Completed Elementary/Secondary (0-12) College (1-4 or 5+) 72 t. Pages I and 2 should be filed within 72 rment of Health and Mental Hygiene.
riant: If item 27 is marked other than "
y or other traumatic event, the Medical. Kepair marked other than MD 21215-0036 to. 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be WYENCE (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b Mailing Address 19a. Informant's Name/Relationship (Type, Print ) ဥ 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 3-11-08 Removal from State Burial 2 Cremation 3 elmar. d 4 Donation 5 Other Specify: 22. None and Address of Facility W. Isaheik 21. Si Bennie Smith Funeractione Sali ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and e, or complic **Physician** failure. Laurly are cause on each line. Death /Medical Multiple Injuries Immediate Cause (Pinal disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): AMENDED 23a, 27, 28a-f per ME g878 5/1/08 amh signed by the attending physician and the detached for use as the burial - trai Physician/Medical X UNPENDED To the Hospital or Attending Physician: The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Day 3 Ectopic pregnancy Month 23b. Was decedent pregnant in the Fetal death Live birth 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions P.O. 1 Yes 2 V No 3 Probably 4 þ 24b. Were autopsy findings available Completed 24a. Was an Division of Vital Records, has been s prior to completion of cause of autopsy death? performed? ✓ Yes 2 Yes 2 No page 26.Place of Death (Check only one) 25. Was case referred to medical Other<sub>4</sub> Nursing Home 5 Residence 6 Other: Scene Be Hospital: DOA ER/Outpatient 3 Inpatient 2 this No 1 Yes 28d. Describe how injury occurred 28c. Injury at Work? Director: After the d in by the funeral 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) Subject in Motor Vehicle Collision 27. Manner of Death Certification: Yes 2 X No Natural with Fixed Object Find 3/7/08 Find 10:05a Find 10:05a Place of Injury - At home, farm, street, factory, office building, etc. Pending Fnd 3/7/08 hours after death. 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident or Town, State) 3 X Suicide Could not be 50 and Oueen Ave. Salisbury MD determined (Specify) Roadway within 24 hours at To the Funeral I completely filled Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 (Check only one) 2 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 8, 2008 O.C.M.E. Morra 30. Name and a press of person who completed cause of Teath (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Margarita Korell MD. egistrar's Signature 32. R 31. Date filed (Month Pay, Year) State 2008 Registrar OCME

	•	For State of Maryland  State of Maryland  For State Registrar	•	irtment of Heal tificate of Dea			ene . No.	0.01.16	
Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Joseph Thomas	Cox	, Jr.		2. Date of Death Month March 12	Day Year , 2008	3. Time of Death 6:00 a. M	
Examin		4a. Facility Name (If not institution, give street and number)  3165 Twin Oaks Lane  5. Social Security Number  6. Sex. 77. Age (In yrs. In the street and number)	last birthday)	4b. City, Town, or Loca  Huntin  If Under 1 Year   If U		8. Date of Birth (Month, Day, Y June 22	4c. County of Dea	ert thplace (State or Foreign ountry)	
Director		Usual Residence of Decedent	Yrs.	cation		June 22	,1929   Ma	ryland  10d. Inside City Limits	
Ba-f shor	Director	MD Calvert C		eake Beach		100	g. Citizen of What Co	1 X Yes 2 No	
23a or 2 ust be n		10e. Street and Number 3081 Cox Road		10f. Zip Code 207			U.S.A.		
al", or items	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed ₩¥Divorced  12. Was Decedent Ever in U. Armed Forces?  1 □ Yes, Give Year or Dates: 1952-		Was Decedent of Hispan If Yes, specify Cuban, M 1 □ Yes 2() No <i>Sp</i>	nic Origin? (Spe exican, Puerto pec <i>ify:</i>	ecify Yes or No- Rican, etc.)	Black, Whi		
point. Tago: theath and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. I	dent's Usual Occupation kind of work done during DO NOT use retired) uperintende	g most of worki	ing 10	6b. Kind of Business	·	
ad other tevent, the	Be	12 17. Father's Name (First, Middle, Last)	5		Mother's Name	(First, Middle, Ma		Company	
n and Mer Is marke raumatic	٦ ک	Joseph Thomas Cox, Sr.  19a. Informant's Name/Relationship (Type. Print)		ng Address (Street and I		al Route Number,		Zip Code)	
ant of Health it: If Item 27 y or other t		AD Ruriat 3 O Cremation 3 O Removal from State	Place of Dispo cemetery, crei	Box 1158, usition (Name of matory or other place) ony Cemeter		Date 2	$rac{D}{D} rac{20639}{206.00}$ Doc. Location - City of $Owings$ , $M$	_	
Departme Importan any Injur once.		21 Signature of Funeral Service Ligensee		2. Name and Address of 8325 Mt. H	Facility Ra	usch Fun	eral Home		
hysician /Medical xaminer		23a. Part1. Enter the isease, or complications that caused the deat shock, or he inflatione. List only one cause on each line.  Immediate Cause Final disease or condition resulting in death)  a.   Due to (or as a consequence)	ecu				st,	Approximate Interval Between Onset and Death	
physician and is the burial-transit	dical Examiner	Sequentially list conditions, if any leading to the course, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of the course of							
e attending of for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of co	al death 3	□Ectopic pregnancy □ Other (specify)				elivery Day Year	
een signed by th nould be detache	by	Part II. Other significant conditions contributing to death but not res	suiting in the u	ınderlying cause given ir	Part I.	23e. Did tob	\.	to the cause of death? Probably 4 □Unknov	
ate has	Completed						prior to death? No 1 □ Ye		
r this certificate ral director, pag	To Be		ER/Outpatie	nt 3 DOA Other:	4 ☐ Nursing H	th Check onl one ome 5 Reside 28d. Describe ho	nce 6 XOther (Sp	pecify) son's ho	
within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	Certification:	27. Manner of Death   Dental   State   Pending   2   Accident   3   Suicide   4   Homicide   Homicide   State	2 □ No		reet and Number or	Rural Route Number,			
24 hours Funeral etely filled	Medical Ce	ause(s) and manner ate and place, and d							
To the	Me	29b. Signature and title of certifier			29c. License number  D 40370  29d. Date signed (Month, 1)  March 12,				
146		30. Name and address of person who completed cause of death (Ite Peter L. Wisniewski, M.D.,		, Print)		Prince F			
St	ate	31. Date filed (Month, Day, Year) Registrar's Sign		oprear Ru.,	,,310			20070	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** EARL F. CULLER March 10 2008 /Medical 2:46 A 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1/7/1928 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 217-24-7192 Director Maryland Usual Residence of Decedent 10c. City, Town or Location with the Maryland 10a. State 10b. County 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at MD Harford Street 1 ☐ Yes 2√ No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1548 Poole Road 21154 USA Funeral 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tyres 2 No If Yes, Give Year or Dates: WWII 1 Never Married Married 1 ☐ Yes 2X No Specify. Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pump Operator City Utility 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be fealth and Mental Marsh Mott Culler Sadie Florence Ferguson ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth E. Culler/Wife 1548 Poole Road, Street, MD 21154 alfimoré, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 3/12/2008 4 Donation 5 Dother (Specify) Bel Air, MD Bel Air Mem. Gardens 21. Signatur of Funeral Service License 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 17314 Part. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Colon Cancer **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter und hing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐No Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ phocytic 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performe Division or Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 □ Yes 2 □ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D35012

12

State 31. Date filed (Month, Day, Year)
Registrar

no 500 Upper Chesapeuke Dr. Bel Air, Md. 21014

182 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LYNCH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 4a c per ind 8 16a b b 21 per fh e877 3-17-08 vt State of Maryland Department of Health and Mental Hygiene Amend Item 1 per dr., g878,0% 11/08 the Death Reg. No 1. Decedent's Name (First, Middle, Last) Margaret Covington 2. Date of Death 3. Time of Death Day 21 Month **Physician** 20 M <del>COV 19 47</del> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Deatl Examiner Montgomery Washington Adventist Hospital 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 176-62-6238 1 □ M 2 X F Hours 86 Yrs. Director 3-6-1921 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. Count 1 ☐ es 2 ☐ No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 13 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Be Completed by 3 Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Housekeeping 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ma Or ۲ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 81 10 ow a Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State Injuntown PA 297 E. Main St lèmeter 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licesee 22. Name and Address of Uniontown, PAISEL Wirter Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician SEPTICEM /Medical Due to (or as a consequence of) Examiner NAL FAIL Sequentially list conditions, if any had a large immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse juence of): Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 HYPOTENS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown FUNGENIA No SECONDARY TO SQTICENT Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an MEII TTU within 24 hours after death.

To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 s autopsy HTN CHYPERTENSION 2 No M 1∏ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Impatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D 05912 28 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

MAL

2008

MAR 15

TASHEEM

31. Date filed (Month, Day, Year)

AVENUE

TAKOHA

PARK

20912

MD

7600 CARROLL

32. pgistrar's Signature

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Doris B. Claar February 23, 2008 11:20 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Stella Maris Hospice If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2XDXF Months 114-05-1914 Yrs. Director Sept.13, 1911 Erie, PA 96 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show her must be notified at 1X Yes 2 No Director Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States 1314 Highland Drive 21239 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status n nem 27 is marked other than "naturai", or iten or other traumatic event, the Medical Examiner Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer Washburn Julia Crouch 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adele B. Strummer/Friend 1314 Highland Drive, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) iny Injury Evans Eagle Crematory 2/25/08 Leola, PA 21. Signature of Funeral Service Incensee 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 17314 and be er the crease, or confidential factions that caused the relation. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Acute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 👿 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CERROY VASCUAR 4/18118 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown MI 318 1sel xxone 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 X No Certification: To Division or 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. EDDIE NAKHUDA 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 200 Wall start OHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 23a per dr. 9877 03/21/08/hb.
State of Maryland Department of Health and Mental Hygiene

1- State Item 23a In b amd per phys dk Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 02, 2008 **Physician** 8:30 PM Estella Savage Devlin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Egle Nursing and Rehab Center Lonaconing 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Country) Maryland Days **Funeral** Hours Min 1 M 2 X F December 04, 1920 87 215-16-4013 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a State 10h County "natural", or Items 23a or 28a-f show ideal Examiner must be notified at 1 Yes 2 No Director Lonaconing Allegany Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number IIS A. 21539 57 Jackson Street by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 12. Was Decedent Ever In U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 3 ₩Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Medical (Give kind of work done during most of working life. DO NOT use retired) other than " Elementary/Secondary (0-12) College (1-4or 5+) Food Grocery 0 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Craig Atkinson Is marked Playford Ross Savage ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14014 New Georges Creek Road SW, Frostburg, Maryland, 21532 William Devlin - Son 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition March 06 permit. Pages Department of I Important: If It any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State St. Mary's Catholic Cemetery Lonaconing, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Property of Pacific Property of P 21. Signature of Funeral Service Licenses 8 East Main Street, Lonaconing, Maryland, 21539 3 23a. Pen1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** eumon'i disease or condition resulting in death) /Medical Que to (or as a consequence of): Disease Examiner -heimer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed iding physician and ise as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performe certificate 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Vursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 1 ☐ Yes 2 No 1 Inpatient Certification: To this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred filled in by the funeral 28c. Injury at Work? s after death. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 3:2008 n09331 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. DONALD Manger 14427 Hazen Rd. N.E. Cumbercand, ND 21502 32. Régistrar's Signature 31. Date filed (Month, Day, Year) State 2008 5 Registrar

			1 - For State Registrar	State of Marylan	id / Depa		lealth and N	/lental Hy	giene Reg. No 🖸 🗍	gible.	08421
	Physicia /Medic		Decedent's Name (First, Middle, La.	Annette	Doye			2. Date of De Month February	Day	Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give Prince Georges Communication)	· ·		4b. City, Town, o	r Location of Death		4c. Cour	nty of Death	
	uneral irector		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Bir								lace (State or Foreign try)
Maryland	a-f show fied at	tor	Usual Residence of Decedent  10a. State 10b. County  D.C.		y, Town or Lo				·	1	0d. Inside City Limits
with the	sa or 28a t be not	1 Direc	10e. Street and Number 5545 B Street, S.E.			10f. Zip Code			10g. Citizen o		try?
fled within 72 hours after death with the Maryland	of other than "natural", or items 23a or 28a-f show to other than "natural", or items 23a or 28a-f show event, the M. di-al Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	14. R	lace - Americ lack, White, city: Blac	etc.
72 ho	"natur	leted	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	pation during most of worl	king	16b. Kind of	Business/Ind	dustry
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ould be file	arked oth	To Be (	17. Father's Name (First, Middle, Last Delano Doye		-		18. Mother's Nam		Maiden Surn	ame)	
nd 2 sh	27 is m r traum		19a. Informant's Name/Relationship ( Shamilya Watkins	**		ng Address ( <i>Street</i> Heatherwick					ŕ
Pages 1 a	Department or neating and whentar rygenes important: If item 27 is marked other than any injury or other traumatic event, the Monee.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Special	Removal from State	Place of Disponentery, cre-	osition (Name of matory or other place Crematory		Date		n - City or To	wn, State
permit.	Importa any Inj once.		21. Signature of Juneral Service Lice	Rueman	/	2. Name and Addre					
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cate be executed	physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. freyme  Due to (or as a consequence)  Due to (or as a consequence)	ma	ف					
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equires that	been signed by the s should be detached t	þ	Part II. Other significant conditions	contributing to death but not res	ulting in the u	inderlying cause giv	en in Part I.				ne cause of death? eably 4/2/Unknown
in: The law re	After this certificate has be funeral director, page 2 sho	e Completed	25. Was case referred to medical				26. Place of Dea	1□ Yes	psy ormed? 2 No	prior to co death?	psy findings available mpletion of cause of 2□ No
hysicia	this cer al direct	To Be	examiner? 1 ☐ Yes 2 ☐ No		ER/Outpatier		er: 4 Nursing H	ome 5 ☐ Resi		Other (Specif	y)
ndlng P	r: After	tion:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 ∐ No	28d. Describe	how injury occ	curred	
tal or Atte	willin 24 hours after usatin.  Fo the Funeral Director: A completely filled in by the fu	Certification	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	building, etc. (Special	fy)			City or To	wn, State)		il Route Number,
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To th	To th	Me	29b. Signature and title of certifier	Brook	m	29c. Licens	e number		29d. Date sig	ned (Month,	Day, Year)
(	01		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type,	Print	7018	3	الم	24/6	Ø
	Sta	te.	Dr. Faven Broom 31. Date filed (Month, Day, Year)	3# Registrar's Signa	Sprtal ature	Drive	Chever	14 MD	207	-85	
	Registr		31. Date filed (Month, Day, Year) MAR 0 4 20	JO France D	. And	when the					

7. Age (In yrs. last birthday)

CLINTON

Months

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day,

	ı
Physician	ı
/Medical	ŀ
Examiner	l

4a. Facility Name (If not institution, give street and number)

1. Decedent's Name (First, Middle, Last) ROBERT EDWARD DORSEY, SR.

SOUTHERN MARYLAND HOSPITAL

6. Sex

5. Social Securify Number

FEBRUARY 29, 2008

4c. County of Death

PRINCE GEORGES

12:20A M

9. Birthplace (State or Foreign

**Funeral** 

Director show r 28a-f she notified a

**X**☐ M 2☐ F 579-16-3952 89 FEB. 23, 1919 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b. County Director MD PRINCE GEORGES OXON HILL 10e. Street and Number 10f. Zip Code 'natural", or items 23a or 'dical Examiner must be r 2160 ALICE AVE., by Funeral 20745 12. Was Decedent Ever in U.S. Armed Forces?

X Yes 2 No 194 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1942 1945 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CUSTODIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DANIEL EDWARD DORSEY TELA D. BUTLER DORSEY 19a. Informant's Name/Relationship (Type. Print) ROBERT E. DORSEY, JR./SON 18428 SHANNE DRIVE, ACCOKEEK, MD 20607 Department of Heal Inportant: If item 27 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD VETERANS CEMETERY 03/06/2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
THORNTON FUNERAL
3439 LIVINGSTON HOME, PAAN HEAD, MD LYDIA C. THORNTON JOHNSON MOUSES 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Vustules disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? signed by the atte 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 2 □ No 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24a. Was an has page 2 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Lecrtifying - nysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Mountain Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29b. Signature and the of certifier death (Item 23a) (Type, Print) Name and address of person who completed cause 001

MARYLAND 10d. Inside City Limits 1 X Yes 2 □ No 10g. Citizen of What Country? UNITED STATES Race - American Indian Black, White, etc. Specify: BLACK 16b. Kind of Business/Industry FEDERAL GOVERNMENT

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20c. Location - City or Town, State

CHELTENHAM, MARYLAND

1)18clese Inthow V

> Month Day

23e. Did tobacco use contribute to the cause of death?

Year

1 Yes 2 No 3 Probably 4 Honknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) MAR 0 3

State

Registrar

08-01874

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Celestine Darby 1- For State Certificate of Death Rea. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ March 6, 2008 1527 hrs Medical Examiner CELESTINE DARBY 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Charles Civista Medical Center Birthplace (State or Foreign SOUTH Country) CAROLINA 8. Date of Birth(MM/DD/YYYY) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Min Months Davs Hours Director 223-08-2666 47 SEPTEMBER 19.1960 М Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Y Yes 2 No 28a-f show MARYLAND CHARLES WALDORF the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 905 BARRINGTON DRIVE 20602 UNITED STATES Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 XNever Married Married 2 X No Yes -Specify: BLACK Yes 2 X No specify: 3 Widowed Divorced If Yes, Give Year à 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) nit. Pages 1 and 2 should be filed within 72 hou. riment of Health and Mental Hygiene. Tant: If item 27 is marked on or other trans. Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MEDIA ADMINISTRATIVE ASSISTANT 3 YEARS 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) DATSY BELL LILLIAN OWENS WILLIAMS DARBY WESLEY DARBY, JR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) JOHN DARBY / BROTHER 6303 BELUGA COURT, WALDORF, MARYLAND 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition fimore, crematory or other place) 1 Burial 2 ACremation 3 Removal from State BRINSFIELD-ECHOLS CREMATORY MARCH 14,2008 CHARLOTTE HALL, MARYLAND Donation 5 Other Specify 21 Sunature of Funeral Service Lice LYDIA C. THORNION JOHNSON MO0583 22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 2064 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Cardiac arrhythmia Immediate Cause (Final disease xaminer Due to (or as a consequence of): Hypertensive cardiovascular disease or condition resulting in death) Hyppertensive ca Sequentially list conditions, Due to (or as a consequence or). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and  $\overline{X}$  AMENDED Pt. I line b per ME, C879 5/9/PI line a-b, 27, per ME,C879 5/8/08 Physician/Medical X UNPENDED attending physician or use as the burial the Hospital or Attending Physician: The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Fetal death Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed ficate has been s. page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital examiner? Hospital: 1 / Inpatient Other<sub>4</sub> DOA Nursing Home 5 Residence 6 2 ER/Outpatient 3 this 1 V Yes No 28a. Date of Injury (Month, Day, Year) the funeral 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Certification: 1 X Natural Yes 2 No Pending death. 2 Accident Investigation completely filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 24 hours after 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. March 7, 2008 en my linal iniD 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001 **OCME 2006** 

Registra

2008

**OCME** 

MAR 1

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav DERRICKSON-STEELE 0/224M 08 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 □ M 2 🕱 F 221-30-3252 60 SEPT 2, DELAWARE 1947 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits DELAWARE SUSSEX 1 ☐ Yes 2 ☑ No DAGSBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30293 PINEY NECK ROAD 19939 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Specify WHITE 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL TRANSCRIPTIONIST HEALTH CARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES R. DERRICKSON NORMA BANKS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JERRAD STEELE / SON 30622 TOWNSEND DRIVE, FRANKFORD, DELAWARE 19945 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State GEORGE'S CEMETERY MAR 8, 2008 CLARKSVILLE, DELAWARE ST. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility WATSON FUNERAL HOME 211 WASHINGTON STREET, MILLSBORO, DELAWARE 19966 MO0 268 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final unkniws Carcinoma disease or condition resulting in death) Due to (or as a consequence of) Smokins Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 Z No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? vom 66 cy to 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes P□ No 24a. Was an autopsy performe 2/2 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2<del>□</del> No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 / Accident

**Physician** /Medical Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f show

Items 23a

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'natural",

Is marked

item 27 l

Pages nent of h Department of Important: If It any injury or o

Baltimore, Maryland 2121

Box 68760.

P.O.

Division or Vital Records,

Director

Funeral

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Completed

Be

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other traumatic event, the Medical Examiner must be notified at

Examine

Physician/Medical

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Completed

Be

2

Certification:

Medical

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

as the burial-trans attending physician

certificate be signed by the a has certificate this funeral After death. al or Attend after death the filled in by within 24 hours a

To the Funeral I

BA 6

State Registrar

29c. License number D39204

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Salubury, MD 2180/

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bennett 31. Date filed (Month, Day, Year)

6 ☐ Could not be

2008

Penninsula 32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 7:05 PM Driscol1 01 29 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Coastal Hospice at the Lake Salisburg Wicamico If Under 1 Year If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2□F Days Hours 86 Director 9-25-1921 215-12-6383 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits Items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2X No Director MD Wicomico Mardela Springs 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? 11295 Sneathen Church Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married ò 1 ☐ Yes 2 No Specify Specify.White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe Harvey T. Brown, Sr. Addie Pearl Parsons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21837 S Jennifer Willing - Granddaughter 11295 Sneathen Church Rd., Mardela Springs, MD Department of Heal Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, Maryland Charity U.M. Cemetery 2-1-2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listorily one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DRMENTIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY SYNDROWR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | 3 | Probably 4 | Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 1 Impatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. Hospital or Attending Physician: Director:

21215-0036

Maryland

ltimore,

24

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

00058410

01-30-08

29d. Date signed (Month, Day, Year)

P.D BOX 1733 SALISBURY mg 21802 HOSPICE COASTAL WARLS

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Medical

29a. Certifier

one)

(Check only

29b. Signature and title of conffier

			For State Registrar	State of Marylan	-	rtment of H tificate of L			0.0	0.0	00100
	3800		Registrar  1. Decedent's Name (First, Middle, Las.	t)	Cei	uncate or L	Jeani	2. Date of De	Reg. No.	UÜ.	3. Time of Death
Į,	Physici	_	William Arth			Month March	Day 1 2	Year 008	3:12 P <sup>M</sup>		
	/Medic Examin		4a. Facility Name (If not institution, give	4b. City, Town, or	ty, Town, or Location of Death 4c. County of				3.12		
	LAGIIII	ê.	10530 Dern Road			Emmit	sburg		Fred	ericl	k
	Funeral		Social Security Number     6. Security Number	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	v, Year)	9. Birthp	nlace (State or Foreign ntry)	
	Director		219-04-05/4	<sup>M M 2□ F</sup> 26	Yrs.			March 1	4, 1981		insylvania
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	Maryi f sho fed a	ō	Maryland Frederi	lok	Emmitsl	111°C					1 □Yes 2 No
	the 28a-	Director	10e. Street and Number	LCR	IJIIIII I C 3 i	10f. Zip Code			10g. Citizen of W	√hat Cour	ntry?
	3a o	<u>e</u>	10530 Dern Road				21727		Uni	ted S	States
	deat	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp	pecify Yes or No	- 14. Race	e - Americ k, White,	ean Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1  Yes 2  No If Yes, Give Year or Dates:		1 □ Yes 2⊠ No	Specify:		Specify	T T1_	ite
21215-0036	72 hou natura lical E	Completed I	15. Decedent's Ed (Specify only highest grad	ucation	16a. Deced	lent's Usual Occupa	ation Juring most of war	kina	16b. Kind of Bu	siness/In	dustry
2	ithin 7 9e. Nan "r	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	)	ung			
7	led w lygier her th	S	11			Truck Dri	ver 18. Mother's Nam	o (Eirot Middle		rucki	ıng
and	be fil sd oth	Be	17. Father's Name (First, Middle, Last)							e)	
Maryland	hould d Mei mark maric	ဥ	Samuel C. Eyler  19a. Informant's Name/Relationship (7	Type Print)	19h Mailir	ng Address (Street a		R. Angle		State Zir	Code)
<u>⊠</u>	nd 2 s Ith ar 27 is 1rau		Anna R. Eyler / N		1	O Dern Ro			Marylan		
ē,	f Heal	13	20a. Method of Disposition	20b. I	Place of Dispo	sition (Name of natory or other plac	i	Date ch 4,	20c. Location -		
Ë	Page lent o nt: If		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	•	Crematory		2008	Frederi	ick,	Maryland
altimore,	mit. partm porta y Inju		21. Signalure of Funeral Service Licen			2. Name and Address		auffer l			
<u> </u>	e a m e e	7. 3	104 E. Main Street Thurmont, Maryland 21788								
×			23a. Part1. Enter the disease of comp shock, or heart failure. List only	olications that caused the deal one cause on each line.	th. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
(a)	Physician	e i	Immediate Cause (Final disease or condition	a Self int	licto	ed Gui	nshor	Luo	und	14	seconds
	/Medical Examiner	Due to (or as a consequence of):									
	陈	10	Sequentially list conditions,	b. Due to (or as a consec	uence off:				-		
	nted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,	,						
Ć.	execting and ial-tra	Еха	resulting in death) Last	Due to (or as a consec	quence of):						
68760,	ficate be executed physician and is the burial-transit	dical		d							
89	ng ph		IF FEMALE:		-						_
Box	ath ce tendii or use	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy	,		i	te of deliventh	ery Day Year
0.	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of e 9☐Unknown	death 5□	Other (specify)			1		24,
S, P.	that the ed by detac		Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use cont	ribute to t	he cause of death?
rds	quires n sign Ild be	d by	Alcohol 6	House				1 🗆	Yes 2 No	3□ Prof	bably 4 □Unknown
or Vital Record	aw requir s been si should	Completed						24a. Was	an 24b.		opsy findings available
Ä	The lay te has age 2	m o						auto perfe 1□ Yes	ormed?	prior to co death? 1 ∐Yes	ompletion of cause of
ţ	ilcian: Th certificate ector, pag	BeC	25. Was case referred to medical				26. Place of Death (Check only one)				
<u>_</u>	Physic this ce al direc	To E	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Oth	er: 4 ☐ Nursing H	ome 5 Res	idence 6 □Oth	er (Speci	fy)
n o	ding Physician: The n. After this certificate ha funeral director, page	ü	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	y at k?	28d. Describe	now injury occur	. /	self
sio	tend leath. tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be	2/1/00	3:00	,	Yes 2 No				al Poute Number
Division	or A after of Direction by	Certification:	4 Homicide determined	building, etc. (Speci	(6/)	our e		City or To	wn, State) / 05	30	Dern Road
_	spita lours neral		29a. Certifier 1☐, Certifying Ph	ysician: To the best of my kn	owledge, deat	h occurred at the tir	me, date and place	e, and due to the	tsbur cause(s) and	anner as s	stated.
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director,	Medical	(Check only 2 Medical Exan	niner: On the basis of examin and manner stated.	ation and/or in	vestigation, in my o	ppinion, death occu	urred at the time	, date and place,	and due t	to the cause(s)
	To the To the Comp	Ĭ	29b. Signature and title of certifier			29c. Licens	e number	,	29d. Date signe	d (Month,	Day, Year)
		30	Man Koli	res MD -	DME	D:	5/17/		Marc	4 -	3, 2008
	a		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	Print) T +4	144	E 1	. /	MA	3, 2008 21701
			31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature W	2>1/	Street 1	reap	rick, 1	4)	61(01
	Sta Regist			008	H A	sally					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🖯 🕕 💍 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Day 2008 Year Physician CLARA Α. **FLETCHER** 7:38 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10 Valleyside Court Montgomery Germantown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 12,1930 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 M 2 F Yrs. Director 227-32-4849 Virginia Usual Residence of Decedent with the Maryland 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Meniat Hygiene. Important: if item 27 is marked other than "natural; or iteme 23a or 28a-f ahow any idury or other traumatic event, Ite Medical Examinat rount be notified at once. 10a. State 10b. County 10c. City. Town or Location 1 Yes 2 No Director Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 Valleyside Court 20874 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 [] Yes 2 [] No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: ۵ 3 XWidowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George L. Boyd 0ra E. Ouesenberrv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daryl L. Fletcher, Son 10 Valleyside Court, Germantown, Md. 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Parklawn Cemetery 3/6/08 Rockville, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee muriel H. Barker P.O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death of Immediate Cause (Final disease or condition resulting in death) cichossis Physician eas /Medical Due to (or as a consequence of): Examiner autoimmone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical use as I attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes Be Completed 24b. Were aulopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy rmed? Division of Vital 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ٩ After this funeral of 28a. Date of Injury (Month, Day Year) 27. Mann of Death 1 Natural 28b. Time of Injury 28c. Injury al Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 2 Accident Director: 3 🗌 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated 29b. Signature and title certified 29c. License number 29d. Date signed (Month, Day, Year) 2008 March completed cause of death (Item 23a) (Type, Pri

Registrar DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day,

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Registrar's Signature

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		71 30	Decedent's Name (First, Middle, Last,			imodic	0			2. Date of Dea	eg. No.		3. Time of Death
	Physici /Medi		Anna Face	chiano		- 1				Month FCD	Day 23	Year	1420
Ì	Examir	ner	4a. Facility Name (If not institution, give Greater Laure). Hea.	street and number) Ith and Reha	b Cente	r	4		vn, or Loo ノアモ	cation of Death	4c. County	of Deeth	ince George
	Funeral Director		5. Social Security Number 6. Sec. 577–26–5639	7. Age (In y	rs. last birthday) Yrs.	If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Aug • 17	Year)	9. Birthpla Count	ace (State or Foreign ry)
	ס		Usual Residence of Decedent		-1					nug. 17	, 1717	-	
	Aaryla F show	ក	10a. State 10b. County  Maryland Prince G		City, Town or Lo							10	ld. Inside City Limits 1 ☐ Yes 21⊠ No
	7 28a-	Director	10e. Street and Number	eorge s	Hyattsv	10f. Zip (	Code			1	0g. Citizen of	What Count	
	th with	aiD	4303 Oliver Street	<b>:</b>		20	783				U.S.A		.,,
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decede fYes, speci 1 ☐ Yes 2		spanic Orig n, Mexican, Specify:	in? (Spe Puerto F	cify Yes or No- Rican, etc.)	Bla	e - America ck, White, e /: Whi	tc.
21215-0020	ithin 72 ho ie. ian "natura i Medical i	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Deced (Give life. L	dent's Usual kind of work DO NOT use	Occupa k done d e retired)	tion uring most	of workir	ng	16b. Kind of B	usiness/Ind	ustry
42	iled w Hygier ther th	Cor	17. Father's Name (First, Middle, Last)	12th	Mu	sic T			da 81	(Flora 16 4 d)	Music	,	
an	lid be i lental i ked of	To Be	Biagio Vagnoni					Rosa		(First, Middle, I apone	walden Suman	1e)	
Maryland	2 shou and M is mar aumet	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	g Address (	(Street a			l Route Number	, City or Town,	State, Zip	Code)
e,	and and a Health		Biagio V. Facchia		604 B	artel.	1 Av	enue,	Lin	thicum	Height	s, MD	21090
nor	ages int of h t: If ite y or of		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	. Place of Dispo cemetery, cren	natory or oth	he <i>r pl</i> ace			2/29	20c. Location -	•	
Baltimore,	mit. Poartme		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	- 1	ate of H						ilver S	Spring	, MD
m	P P P P P P P P P P P P P P P P P P P	(5)	Mana A t	353						AL HOME,		nrino	, MD 20904
1	Physician /Medical Examiner	8 12	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the delecause on each line.  Aspira Fi	•					r respiratory arre	est,	1	Approximate Interval Between Onset and Death
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	xecute al-tran	Examiner	Sequentially list conditions, if any, leading to immediate	Sigmold	(or as a conseq	uence of):			, .	, ,			. 1,
Box 68760	leath certificate be executed attending physician and for use as the burial-transit	Physician/Medical E	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Signic Due to	(or as a consequ		er	tici	111	+13			1 month
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Vital Kecords,	w requi	Completed	+FIN Failure	to thri	16					24a. Was a perform		avai	e autopsy findings lable prior to pletion of cause eath?
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<b>&gt;</b>	Physician: this certific ral director,	e Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:			Other	20000000		(Check only on			
on of	ding Phy h. After this funeral d	tion: To	27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury		c. Injury : Work?	4 No Nurs	2	e 5 Reside 8d. Describe ho			
DIVISION	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre			2 2 1	_	8f. Location (St. City or Town	reet and Numb , State)	er or Rural	Route Number,
	Hospi 4 hou Funer tely fill	edical	29a. Certifier 1 Certifying Physi (Check only one) 1 Medical Examin	ician: To the best of my kr er: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at estigation, in	the time	, date and nion, death	place, er	nd due to the ca	use(s) and ma ite and place,	nner as sta and due to t	ted. he cause(s)
	To the within 2 To the complete	ž	29b. Signature and title of certifier	ATTE	NDING		License		16-		d. Date signe		_ /
)	3		30. Name and address of person who cor		em 23a) (Type, F	Print)		572			rcb.	27	2008
	C.				3450	Lauri	$el, \Lambda$	AD 2	107:	24 FT	. mel	(d 2/	5, CD #209
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DHMH 16 Rev 6/95

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	Physici /Medi		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Month 1.111van Farmer  1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Month 1. Day 1. Da											3. Time of Death 8:05pm M	
	Examir		4a. Facilify Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Timonium								4c. County of Death Baltimore				
	Funeral Director			Sex 1 □ M 2 <del>Q</del> F	7. Age (In yrs. 8		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	1920	9. Birthplace (State Country) Ldaho		
	should be filed within 72 hours after death with the Maryland and Mental Hygiene. In Mental Hygiene and the than "natural" or items 28a or 28a-f show umatic event, the Medical Examiner must be notified at	Funeral Director	10a. State 10b. County	Arundel		y, Town or Lo	10f. Zip		144			10g. Citiz	en of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☑ No ntry?	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heath and Mental Hygiene. International files of the stranger of the firm 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  15. Decedent's E	12. Was Dec Armed Fo 1  Yes, Gi Yes, Gi Year or D	□Yes 2 ☑ No Yes, Give 1 □ ear or Dates:			21144  Vas Decedent of Hispanic Origin? (Sp. Yes, specify Cuban, Mexican, Puerto  ☐ Yes 2X No Specify:  ent's Usual Occupation			specify Yes or No- to Rican, etc.)  14. Race Black Specify:		4. Race - Ameri Black, White,	e - American Indian, k, White, etc. · White	
. <i>P.M.</i> Maryland 21215-0036	filed within 7 Hygiene. other than "n ent, the Medi	Completed by	(Specify only highest gr	College (	1-4or 5+)	(Give life. L Age	kind of wor DO NOT us nt	k done d e retired				1	Real Est	ate	
.M.	hould be fill de Mental He marked ott matic even	To Be	17. Father's Name ( <i>First, Middle, Las</i> Lars Jensen  19a. Informant's Name/Relationship			10b Moilie	um Addraga	(Street )	Mar	ie	(First, Middle			- Cardal	
:05 P.	1 and 2 sho Health and lem 27 is mi			aughter	20b. P	7918	Citad	e1 ne of	Dr.	Seve	ern, MI	2114	r, City or Town, State, Zip Code) 21144  20c. Location - City or Town, State		
8:05 Baltimore.	permit. Pages Department of I Important: If ite any injury or o		1 ☐ Burial 2 2 ☐ Fremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Service Lice	fy)	State	emetery, crer tro Cr	emato	ry			/2008	Balt	imore,	MD	
B	permi Depar Impor any ir		Datify M 12 Ridgely Ave. Annapolis, MD 21401												
C	Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death)	a. Ath Due to	oach line.  VOSC  (or as a consequ	lcroh uence of):							ease	Approximate Interval Between Onset and Death	
2008 <b>68760</b> .		edical Examiner	g										23d. Date of delivery		
. 26, Box	The law requires that the death certifica to has been signed by the attending phoage 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live I 4□Pregr 9□Unkn		Ideath 3 = eath 5 =	Ectopic pro	ecify)					Month	Day Year	
FEBRUARY Records. P.O.	w requires tha been signed should be de		Part II. Other significant conditions	contributing to d	eath but not resu	alting in the ur	nderlying ca	ause give	en in Part I					the cause of death? bably 4 AUnknown	
Rec		Completed		·							1□ Yes	psy ormed? 2 (No	24b. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of	
N FARMER	ing Phy After this uneral d	ion: To Be	1 Yes 2 No Tospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									ity)			
LILLYAN Division		27. Manner of Death  15   Pending investigation  3   Suicide   Homicide   Could not be determined   Sec. Place of injury - At home, farm, street, factory, office   286. Injury at work?  1   Yes   2   No   286. Injury at work?  1   Yes   2   No   286. Injury at work?  1   Yes   2   No   286. Injury at work?  286. Injury at work?  1   Yes   2   No   286. Injury at work?  287. Injury at work?  288. Date of Injury   288. Injury at work?  288. Date of Injury   288. Injury at work?  288. Date of Injury   288. Injury at work?  288. Date of Injury   288. Injury at work?  288. Date of Injury   288. Injury at work?  288. Date of Injury   288. Injury at work?  288. Date of Injury   288. Injury at work?  288. Date of Injury   288. Injury at work?  288. Date of Injury   28									Street and wn, State)	eet and Number or Rural Route Number, State)			
1	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one)  1. Certifying P 2 Medical Exa	miner: On the b	e best of my kno- easis of examina ner stated.	wledge, death tion and/or in	vestigation,	in my o	pinion, dea	nd place, ath occurr	and due to the ed at the time	cause(s) a , date and	and manner as s place, and due	stated. to the cause(s)	
0	To the within To the comple	Δ	29b. Signature and title of certifier	-			290	License	number	25			signed (Month,		
_	lew		30. Name and address of person who TARIQ MAHMOOD,	M.D. 2	300 DUL	ANEY V	,	ROA	D T	IMON:	TUM, MI	2109	93		
	Sta Registr	ar	31. Date filed (Month, Day, Year) FEB 2 9 20	008	negistrar's Signa	k fo	antie								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [] 1 - For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** 27, 2008 February 7:00A. Mary Grace Finegan /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Vincent Care Center Emmitsburg
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Frederick 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 ₩ F Director 92 1915 214-54-6261 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10c. City. Town or Location 10d. Inside City Limits 10b. County of Heelth and Mental Hygiene. Item 27 Is marked other than "naturel", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Frederick Emmitsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Completed by Funeral 21727 335 South Seton Avenue 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No tf Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Religious Community Elementary/Secondary (0-12) Coltege (1-4or 5+) Daughters of Charity College 5+ Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Francis Gordon Grace Roper 19a Informant's Name/Relationship (Type, Print) Mother Superior Sister Camilla Harant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 333 S. Seton Avenue, Emmitsburg, MD 21727 20a. Method of Disposition Date 20c. Location - City or Town, State 20h Place of Disposition (Name of Stemeter) (Name of Stemeter) Department of Important: If it eny injury or concentrations 1 Surial 2 □ Cremation 3 □ Removal from State 3/3/2008 Provincial House Emmitsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Myers-Durboraw Funeral Home 210 W. Main Street, Emmitsburg, MD 21727 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mon /Medical Due to (or as a consequence of) Examiner Wall 100 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attending physicien and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed harof c Due to (or as a consequence of): Box 68760, IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 within 24 hours after death. To the Funeral Director: After this centificate has been signs completely filled in by the funeral director, page 2 should be 1 ☐ Yes ÅD'No 3 ☐ Probably 4 ☐Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 **⋈** № 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: Certification: To 1 ☐ Yes 2√2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide to Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause so and manner as state.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 MJ Rough cause of death (It am 23a) (Type, Print) 30) Name and address of person who completed EC 31. Date filed (Month, Day, Year) 32. Regierrar's Signature

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 2:25 2008 March p ELAINE RUTH GRIMM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Garrett Oakland Nursing and Rehab Oakland Jnder 1 Year | If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5, Social Security Number Min. **Funeral** Months Hours 1 □ M 2 □ F Yrs. 6/13/1931 WV 236-84-4948 Director Usual Residence of Decedent 10d Inside City Limits Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other then "neturel", or Items 23a or 28e-f show 10c. City, Town or Location 10a. State f Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23a or 28e-1 show other traumatic event, the Medical Examiner must be traited at 1 ☐ Yes 2 X No Director WV Preston Aurora 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 26705 U.S. HC 82 Box 14 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 💥 📉 No Specify Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Domestic Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wvelyne Smith Arnold unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 82 Box 14, Aurora, WV HC Robert D. Grimm 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition n Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Pages Department of Importent: If it eny injury or o 3/6/2008 Aurora, WV Aurora Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Arthur H. Wright Funeral Home 105 Highland Ave., Terra Alta, Katheine Swettyer WV 26764 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 week 545 tolic diastolic Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial-transit requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9☐Unknown in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. 5 2 X No 3 ☐ Probably 4 ☐ Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an intermittent atria autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death Check onl one To the Hospitel or Attending Physician: Be Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 28d. Describe how injury occurred 27. Manner of De th 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 1 Natural 2 Accident 5 Pending investigation 2 🗌 No death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after death To the Funerel Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be determined 3 Suicide 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie of person who completed cause of death (Item 23a) (Type, Print) oahland MA 21552 32. Registrar's Signatur 31. Date filed (Month, Day, Year) Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Noc 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** RICHARD Ε. GROSSMAN 3:44 P M 2008 March 1, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 01/10/1932 9. Birthplace (State or Foreign Country) Rhode Island 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F 035-22-0301 76 Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Director MD Montgomery Bethesda 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 2 iner must be n 8020 Cindy Lane U.S.A. 20817 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 1953-56 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status r than "natural", or Iten the Medical Examiner Black, White, etc. filed within 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Co-owner Custom Lighting s 1 and 2 should be filed wi f Health and Mental Hygier item 27 Is marked other th other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Grossman Zelda Podrat 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tra Judy Grossman - Wife 8020 Cindy Lane, Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance 03/05/2008 Clarksburg, MD 21. Signatur of Funeral Service Licensee Edward Sagel Funeral Direction, Inc. 1091 Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pulmonary Embolism /Medical Due to (or as a consequence of) Examiner months Metastatic Adenocarcinoma Sequentially list conditions, Physician/Medical Examiner if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-tran Due to (or as a consequence of): physician s the burial P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1□ Yes 2**∏** No Vital 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 0 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Division 5 ☐ Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 066304 Dr. Tagoro, MD 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Tagoro, MD 8600 Old Georgetown Rd, Bethesda, MD 20814 31. Date filed (Month, Day, Year) 32. egistrar's Signature State 03 MAR 2008 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear Francis Greenfield February 28,2008 1:20p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 14752 Bassford Road Hughesville Charles 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5 / 11 / 1923 9. Birthplace (State or Foreign Days 1**X**M 2□F Hours 84 Vrs Maryland 218-24-6973 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Maryland Charles Hughesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14752 Bassford Road 20637 USA Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Skilled Labor Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Greenfield Mary Edith Edelen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara Greenfield/Wife 14752 Bassford Rd.Hughesville,Maryland20637 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State

22. Name and Address of Facility

3/5/08

Bryantown, Maryland

Adams Funeral Home PA

29d. Date signed (Month, Day)

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event;

Pages nent of !

**Physician** 

/Medical

Examiner

10a. State

Funeral Director

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Completed

Be

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4 Donation 5 Dother (Specify)

21. Signature of Fuheral Service Licensee

29b. Signature and title of certifier

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2008

Funeral

Director

filed within 72 hours after death with the Maryiand

Baltimore, Maryland 21215-0036

2 should be filed within 1/2 momental Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show and the event, the Medical Examiner must be notified at

physician and s the burial-transit attending ph signed by the a has cate thin 24 hours after death.

the Funeral Director: A
mpletely filled in by the fu

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician:

	Turk	191 20605 Aguasco Ro		rland 2060
	23a. Part1. Enter the disease, or com- shock, or heaft failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death. Do not enter the mode of dying, such as cardial one cause on each line.  a. DV BWC(W) HTT+CWC Company.  Due to (or as a consequence of):		Approximate Interval Between Onset and Death
ıminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b		0
dical Exa	resulting in death) Last	Due to (or as a consequence of): d.		
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of de Month	livery Day Year
ted by P	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	
Comple			24a. Was an autopsy performed? 1 Yes 2 No 1	utopsy findings available completion of cause of s 2 No
To Be	25. Was case referred to medical examiner?  1 Tyes 2 You	Hospital:	ath <i>(Check only one)</i> Home 5 <b>万</b> Residence 6 □Other <i>(Spe</i>	ecify)
ation:	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury  By Sec. Injury at Work?  1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	
ical Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or R City or Town, State)	
ca Ca	29a. Certifier 1 Sertifying Ph	ysician: To the best of my knowledge, death occurred at the time, date and place niner: On the basis of examination and/or investigation, in my opinion, death occu	e, and due to the cause(s) and manner as urred at the time, date and place, and du	s stated. e to the cause(s)

29c. License number

St. Marys

DHMH 17 Rev 1/2001

State

Registrar

TO 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician Gende 10M Margare inia March 0 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner River hester Hospital Mester town Ma en4 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 ☐ M 2 🗶 F 94 3/23/1913 PA Director 185-30-2604 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 1X Yes 2 No r 28a-f sh notified **KENT** CHESTERTOWN Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ns 23a or 2 must be n Pages 1 and 2 should be filed within 72 hours after death with USA 21620 415 MORGNEC RD. by Funeral ral", or items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 **X** If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No WHITE Specify: 3 ₩Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than "naturaumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) HAIRDRESSER BEAUTY 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RENETTA SCHMIDT JOSEPH JOHN RILEY ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any Injury or other trauonce. 331 BURCHARD SAWMILL RD. CHESTERTOWN, MD 21620 JOEL TAYLOR/SON 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State DAVIDSONVILLE, MD 4 Donation 5 Dother (Specify) LAKEMONT MEMORIAL 3/6/2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME un 130 SPEER RD. CHESTERTOWN, MD 21620 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on the cardiac or respiratory arrest, shock, or heart failure. Immediate Cause (Final Physician neumon disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of perfo death? 1 ∐ Yes 21 No 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital. 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death.

To the Funeral Director: completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29c. License number 29d. Date signed (Month Day, Year) 29b. Signature and title of certifie Q 2 completed cause of death (Item 23a) (Type, Print) Name and address of perso

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Bertha Gray 03 02 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death REGIONAL Salisburg Ui COMICO If Under 1 Year | If Under 24 Ars. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1 ☐ M 2X F 85 212-32-8611 1, 1922 May Pennsylvania Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Wicomico Salisbury 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 30024 Southampton Bridge Road 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ♣ No Specify Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry

Grocery Store

18. Mother's Name (First, Middle, Maiden Surname)

Meat Wrapper

Maryland 21215-0036 traumatic event, the Medical marked other s 1 and 2 should be fil f Health and Mental H tem 27 is marked oth ortant: If item 27 Injury or other to Baltimore, Pages 1 Important; t any Injury o Department

**Physician** 

/Medical

Examiner

10a State

MD

Elementary/Secondary (0-12)

11

17. Father's Name (First, Middle, Last)

College (1-4or 5+)

**Funeral** 

Director

t be notified at

ms 23a

"natural", or items

Funeral Director

Completed by

Be

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Examine

Physician/Medical

Completed by

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Medical Certification: To

filed within 72 hours after death with the Maryland

**Physician** /Medical Examiner

be executed

burial-trar physician the burial attending pl þ signed b d be deta page 2 should certificate has funeral director, this After t

P.O. Box 68760, Records, Vital Physician: Division or To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Registrar

Rizzo Alphonzo Maristina Renzi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Baraby- Daughter 30024 Southampton Bridge Rd. Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ICremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 3/3/2008 Delmar, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 23a. P. 11. Enter the disease, or common tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only or e cause on each line. Salisbury, MD 21804 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, it any, learning to unimodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nunknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Inhmara/ap 6/6/ 32. Pygistrar's Signature 31. Date filed (Month, Day, Year) 2008 MAR 03 ORIGINAL

08-01718 Jesse Allan Gay

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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2008	13	i.i.	0	-

336 Allah Gay		I- For State	Certificate o	f Death	Reg. I	<u> </u>	0 0040
Physicia	_	Registrar 1. Decedent's Name (First, Middle,Last)			2. Date of Death		3. Time of Death
edical Exami		JESSE ALAN	GAY		Month Da February 29,	2008	0936 hrs
		<ol> <li>Facility Name (if not Institution, give street are</li> <li>7900 Esham Road</li> </ol>	d number)	4b. City, Town, or Location of Death Parsonsburg		4c. County of Death Wicomico	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min		MM/DD/YYYY) 9. Birt Foreig	n
Director		222-78-8727 1X M 2	]F 20 Yr		MAR 09,	1987 Co.	untry) VIRGINIA
any	ŀ	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loca	ation			10d. Inside City Limits
<b>≱</b> ್ತ	'n	DELAWARE SUSSEX COUN	TY MILLSBOR	0			1 X Yes 2 No
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number		10f. Zip Code		Citizen of What Cour	
ith the 23a or notifie		33 MILLERS RUN  11. Marital Status 12. Was	Decedent Ever in U.S. 13. W	19966  Vas Decedent of Hispanic Origin? ( S			can Indian, Black,
eath w	Funeral	1 X Never Married 2 Married Arm		Yes, specify Cuban, Mexican, Puerto		White, etc.	
after d	by Fi	3 Widowed 4 Divorced If Yes, Giv	e Year 1	Yes 2 X No specify:	177	Specify: WH	
hours "natur		15. Decedent's Education (Specify only highes  Elementary/Secondary (0-12) Colle		ent's Usual Occupation (Give kind of most of working life. DO NOT use re		6b. Kind of Business/	ndustry
5-0036 led within 72 Hygiene. other than the Medical	Completed	12		ER/OPERATOR		DOG BREED	ER
e, MD 21215-0036  I and 2 should be filed within 7  Health and Mental Hygiene.  item 27 is marked other than r traumatic event, the Medica		17. Father's Name (First, Middle, Last)			e (First, Middle, Mai	den Surname)	
2121 ould be f Mental marked ic event,	o Be	RONALD ALAN GA 19a. Informant's Name/Relationship (Type, Print		JOYCI ng Address (Street and Number or		r. City or Town, State	, Zip Code)
MD 2 rd 2 shou alth and M m 27 is r aumatic		JOYCE C. GAY (MOTE	181	ILLERS RUN , MIL	LSBORO, DI	E 19966	
nore, MD 2121 ges I and 2 should be fi nt of Health and Mental t: If item 27 is marked other traumatic event,		20a. Method of Disposition  1 X Burial 2 Cremation 3 Remo		osition (Name of cemetery, other place)	Date 2	20c. Location - City or	Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify:	WOODLAWN		RO5,2008	MILLSBORO	, DE 19966
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and Iv Important: If item 27 is m injury or other traumatic.		21. Signature of Funeral Service Licensee	MO 1365 W	Name and Address of Facility  ATSON FUNERAL HOR			19966 SBORO, DE
Physician		23a. Part I. Enter the disease, or complications failure. List only one cause on each line.	pat caused the death. Do not enter	the mode of dying, such as cardiac	or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and
Medical. ≅ ⊂xaminer		Immediate Cause (Final disease a. Multiple	e Gunshot Wounds				Death
		Sequentially list conditions,  b.	as a consequence or).				
	iner	if any, leading to immediate Due to (o	r as a consequence of):				
d sit	Examine	(Disease or injury that initiated events resulting in death) Last C. Due to (o	r as a consequence of):				
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760, rate be execut physician and he burial - trai	Medical		ves, outcome of pregnancy			23d. Date of deliver	y
687( ertifica ding pl		23b. Was decedent pregnant in the past 12 months?	Live birth 2 1	Fetal death 3 Ectopic pregr	nancy	Month	Day Year
Box 687, he death certific the attending phed for use as the	Physician/	A Non O No O University	Pregnant at time of death 5 Unknown	Other (Specify)			10
b, P.O. Be ires that the de signed by the d be detached f		Part II. Other significant conditions contribu	ting to death but not resulting in the	e underlying cause given in Part I.		acco use contribute to	
S, P uires th n signe Id be d	ed by				24a. Was an		bably 4 Unknown utopsy findings available
cords, aw requi has been 2 should	Completed				autopsy perform	pnor to death?	completion of cause of
Vital Reco ysician: The law his certificate has director, page 2 s		OF Management to marked		26.Place of Death (Chec	1 Yes 2	No 1 ✓ Y	es 2 No
Vital hysician this certi	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Inpatient 2 ER/Outpatie	1Other:		esidence 6 🗸 Othe	er: Scene
of \\ ling Phy After the	<b>-</b>	27. Manner of Death 28a.	Date of Injury 28b. Time of Month, Day, Year) FOUND:		28d. Describe ho Subject shot	w injury occurred	
sion ttendi death. ctor: /	atio	2 Accident Investigation Fe	29, 2008 0920 hrs	1_ Yes 2 V No			ural Route Number, City
Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should I	ertification:	Suicide Could not be determined	. Place of Injury - At home, farm, st ecify) Woods	reet, factory, office building, etc.	or Town, Sta		
Hospit Hospit Euners Funers	ပ	29a. Certifier Certifying Physician: To the	ne best of my knowledge, death occ	curred at the time, date and place, ar	nd due to the cause	s) and manner as sta	ited.
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as if	Medical	one) Medical Examiner: On the l	pasis of examination and/or investi- nner stated.	gation, in my opinion, death occurred	at the time, date ar	nd place, and due to t	he cause(s)
0	Z	29b. SigNature and title of certifier	(1)	29c. License number O.C.M.E.		29d. Date signed (M March 1, 2008	эпш, <i>∪</i> ау, ʏear)
~im		30. Name and address of person who complete	d cause of death (Item 23a)	O.G.IWI.E.			
0				nn Street, Baltimore, MD 21	201		
	tate	. MAD 11 2 2002 I	32. Legistrar's Signature	South 2			
Regis	1441	11111 V 9 4000	Property State All Book	A STATE OF THE STA			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08437 Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CHARLES ERLE HITE MARCH 2008 7:30 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** BEVERLY HEALTH CARE CENTER FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) APR 15 1913 Birthplace (State or Foreign Country)
 OH 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F 94 301-09-8659 Director APR Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a, State 10c. City, Town or Location "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County MD MONTGOMERY CLARKSBURG Director 1 ☐ Yes 2 ✓ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13200 COOL BROOK LANE 20871 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: WHITE 3 ☑Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry SHERWIN WILLIAMS permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) COMPANY SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLIE D. HITE LENA OGLESBEE ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $2309 \ OAK \ DR$ . IJAMSVILLE, MD 2175419a. Informant's Name/Relationship (Type. Print) SARA HARREN / DAUGHTER 2309 OAK DR., IJAMSVILLE, MD 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State STAUFFER CREMATORY 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/4/08 FREDERICK, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HILTON FUNERAL HOME
P.O. BOX 86, BARNESVILLE, 21. Signature of Funeral Service Licensee 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Oneumania WERK /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): burial-tran and resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 21 No 1 Yes 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 ☐ Yes 1□ Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 Other: 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1400 50m 31. Date filed (Month, Day, State Registrar 2008

	,	Division or Vital Records, P.O. Box 68760,	į	Baltim
	(	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	Phy /M Exa	permit, Pag
4	T	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	rsicia ledic amin	Important; any Injury

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/Medi Examii		4a. Facility Name (	If not institution, give	e street and number)	_		4b. City, Town,	or Locatio		rebruar	-	County of Death	1829 "
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Funeral		5. Social Security N	lumber 6. S	ex 7. Ag	e (In yrs. i	last birthda	Months   Davs		er 24 Hrs.	8. Date of Bir (Month, Da	rth	9. Birth	pplace (State or Foreign
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72 hours after death with the Maryland 72 hours after death with the Maryland inatural", or Items 23a or 28a-f show dinal Examiner must be notified at	Director	10e. Street and Nu 1912 Roche					10f. Zip Code	0747			-	izen of What Cou	untry?
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fter de	Funeral	11. Marital Status 1 □ Never Marr	ried 2 Married	Armed Forces?		S. [1	<ol><li>Was Decedent of If Yes, specify Cul</li></ol>	ban, Mexi	can, Puerto	Rican, etc.)	)-	Black, White	
ral", o	l by	3 XWidowed	4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🔀 No	Speci	ify:			Specify: B	lack
within 72 hours giene. r than "natural" the Medical Exa	Completed	(Spec	15. Decedent's Ed	lucation de completed)		16a. De (G	cedent's Usual Occu ive kind of work done e. DO NOT use retire	pation during m	ost of worki	ng	16b. K	ind of Business/I	ndustry
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permit. Pages 1 and 2 should be filed within Deperment of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Manance.			☐Cremation 3 ☐	Removal from State	Res	iace of Dis emetery, c	sposition (Name of crematory or other pla ion Cemeter	ace)	02/23	)ate <b>/2008</b>		ocation - City or T	
nit. Pa ertme ortant Injury			5 ☐ Other (Specify neral Service Licer	<del></del>			22. Name and Addr	-				nton, Mary	/Tar n
permi Deper Impo any Ir		» OX	DANGTON D	x troon	1al	$\bigcirc$	4594 Beech 1	Road:	Temple	am run Hills. M	Marvi:	services and 20748	₹
Syria		23a. Part1. Enter t	the disease, or com	plications that caused one cluse in each lin	the death	n. Do not						20710	Approximate Interval Between
Physician		Immediate Cause disease or condition	(Final		Dirat	1	tailure						Onset and Death
/Medical Examiner		resulting in death)			consequ		. ( )	.11					
	eľ	Sequentially list co	nditions,	b. Due to (or as	Consequ	uence of):	s of it	54n	ma				
uted d ansit	Examin	Sequentially list co if any, leading to in cause. Enter Under that initiated events	erlying injury	,			0.00					0	
executed an and rial-transit		resulting in death)	Last	Due to (or as	a consequ	uence of):							
eath certificate be executed attending physician and for use as the burial-transit	lical			_d									
Sertific ding p	Physician/Medica	IF FEMALE:		23c. If yes, outcome	of pregna	nev							
atten for us	cian	in the past 12	months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death	3 □Ectopic pregnand 5 □ Other (specify)	су				23d. Date of deli Month	very Day Year
t the d by the ached	hysi	1 □ Yes 2 [ 9 □ Unknown		9□Unknown			о <u>ш</u> отног (ороспу) <u>-</u>						
The law requires that the death certificate the has been signed by the attending physicage 2 should be detached for use as the	by P	Part II. Other signi	ficant conditions of	ontributing to death bu	ut not resu	ulting in the	e underlying cause gi	ven in Pa	rt I.	23e. Did	tobacco	use contribute to	the cause of death?
w requires been sign										1 🗆	Yes 2	□ No 3□ Pro	bably 4 Vunknown
has by	Completed									24a. Was	psy /	prior to c	topsy findings available ompletion of cause of
		05 111								1□ Yes	2 No	death? 1 ☐ Yes	2 No
Attending Physician: r death. ector: After this certifica	o Be	25. Was case reference examiner?		Hospital: 1 ☐ Inpatie	nt 2 10/1	ER/Outpat	tient 3 DOA Ot	her:		Check only		6 □Other (Spec	
ig Phy ter this	n: To	27. May er of Deat	th	28a. Date of Injui	ry	28b. Time	e of 28c. Inju			28d. Describe			ny)
endin sath. or: Af	atio	1 Natural 2 ☐ Accident	5 ☐ Pending investigation	1	reary	IIIjui		Yes 2	□No				
or Att fiter de Direct in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of inju building, etc	ary - At ho c. <i>(Specif</i> y	me, farm, /)	street, factory, office		2	28f. Location ( City or To			ral Route Number,
To the Hospital or Attending Is within 24 hours after death. You the Funeral Director: After gompletely filled in by the funer		29a. Certifier	1 Certifying Ph	ysician: To the best of	of my knov	wledge, de	eath occurred at the	time date	and place	and due to the	rallee/e	) and manner as	stated
the Hos nin 24 h the Fur npletely	Medical	(Check only one)	2 ☐ Medical Exam	nîner: On the basis of and manner sta	examinat	tion and/or	r investigation, in my	opinion, o	death occurr	ed at the time	, date an	d place, and due	to the cause(s)
withir comp	Me	29b. Signature and	title of certifier	A			29c. Licen					te signed (Month	n, Day, Year)
(4)		1 (an	Mr.	Ture.			VA - C	1010	349	98	te	b 15,	2008
D		30 Name and add	ess of person who	ompleted cause of de	eath (Item	23a) (Typ	pe, Print)	3000	, ma	198 dicine	79	MDOS, +	AFB, MD
Sta	te	31. Date filed (Mon	th, Day, Year)	32. Registra	ar's Signat	ture	rof binds	Jana	1111EC	riune		•	20762
Registi		31. Date filed (Mon	<b>4</b> ZUU0	General 1	* 1	book	ر م		7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Toppartment of Aleath and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ttuo ASHRAFUL TER 28 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours Min. 54 223-23-7503 Director 01/01/1954 Bangladesh Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 2 No Md. Directo Montgomery North Potomac 10f. Zip Code 10g. Citizen of What Country? 20878 Reed Farm Way U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. ģ Specify: Asian 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Leadsoft Inc. Tech. Software Engineer 5+ 17. Father's Name (First, Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shamsul Huq Anowara ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chemon Huq / wife 14205 Reed Farm Way North Potomac, Md.20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 Surial 2 □ Cremation 3 □ Removal from State George Washington 2/29/08 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, Md. 21. Sign y e of Funeral San 22. Name and Address of Facility Universal Mortuary Licensee 411 Kennedy St., N.W. Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ZMONTHS NEUROENDUCRINE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2D No certificate ha 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death to the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier W MD FEB 28,2008 D0061083

DHMH 17 Rev 1/2001

State

Registrar

Center Drive #30 Rockville, Md. 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

9707

Medical

Thambi MD

MAR 03

31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 08440 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:28 A<sup>M</sup> NANCY JOAN HIGGINS 29 2008 February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
March 30,1932 Washington, DC Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🖾 F 439-44-2594 75 March Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No North Bethesda Directo Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 U.S.A. 5 Whipporwill Court Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2N Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ğ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 2 Years Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willis D. Wine Irene Perry ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Billy K. Higgins/Husband 5 Whipporwill Court, North Bethesda, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 03/03 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 2008 4 □ Donation 5 □ Other (Specify) Rockville, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility
HINES-RINALDI FUNERAL HOME, INC.
11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or rearrial results only one cause on each line. Imm iate Cause (Final disease or condition resulting in death) andiovascular Distase **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vítal Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 menths? 1 ☐ Yes 2 ☑ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Hlnknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 5 Pending investigation 1 Yes 2 No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (*Month*, *Day*, *Year*)

2/29/200 29b. Signature and the of certifier License number address of person who completed cause of death (Item 23a) (Type, Print) Robert Joseph Rothstein, MD, 8600 Old Georgetown Road, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) MAR 0 3 State 2008 Registrar

2/29/08

ifgins, Nancy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5:55 A<sup>M</sup> February 29, 2008 Sharon Rae Hayden /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Potomac
If Under 1 Year
Months Days Montgomery 1708 Sunrise Drive Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🖾 F 219-48-7061 60 March 8, 1947 Washington, DC Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heatth and Mental Hygiene. 9m 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director Montgomery MD Potomac 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20854 U.S.A. 1708 Sunrise Drive Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ∐ Yes 2X No Specify: þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Assistant Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irvin Cutler Pearl Edes ဨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 an Department of Healt Important: if item 27 any injury or other tra once. 1708 Sunrise Drive Potomac, MD 20854 Mark Hayden - Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Lebanon Cemetery: 3/2/08 Adelphi, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licens Danzansky-Goldberg Memorial Chapels, 1170 Rockville Pike Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 8 months Pancreatic Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical for use as IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signe should be d Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performed? /es 2 🔀 No certificate 1∐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation or Attending Injury 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Hospital 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D22775 February 29, 2008 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5454 Wisconsin Ave. Suite 1300 Chevy Chase, MD 20815 Frederick G. Barr MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 03 MAR Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 28, Charles Joseph Ippolito, Sr. <u>February</u> 2008 8:40 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Suburban Hospital Montgomery Bethesda Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1XM 2□F Yrs. Director 050-14-5899 87 10. 1920 Massachusetts April Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County show ed other than "natural", or items 23a or 28a-f showed other, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland|Montgomery Germantown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12205 Major Drive 20876 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 11. Marital Status Black, White, etc. 1 □ Never Married 2 Narried 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1941-63 White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Leiutenant Colonel United States Army marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helena Florence Ahern Joseph Moris Ippolito 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 Health tem 27 i Claudette Ippolito, wife 12205 Major Drive, Germantown, Maryland 20876 permit. Pages 1 and Department of Healt Important: If item 2: any injury or other i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Arlington National Cem. 5/21/2008 Arlington, Virginia 4 Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licers 22. Name and Address of Facility Molesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use Final disease or condition resulting in death) Physician Bilateral pneumonia /Medical Due to (or as a consequence of) Examiner Pulmonary fibrosis Sequentially list conditions, if any, leading to infine distinctions. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Non-Q wave Myocardial Infarction ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2☐ No 9□Unknown 9 ☐ Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1X Yes 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2 XNo or Vital 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Be Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To hours after death.

Ineral Director: After this
y filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Division 1 XNatural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 0 within 24 hours a

To the Funeral I Hospital 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature a D53691 February 29, 2008

Registrar

State

30 Name and address

Ajay Reddy,

MAR 0 3 2008

31. Date filed (Month, Day, Year)

15

6320 Democracy Boulevard, Bethesda, Maryland 20817

of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No.-3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March 2008 02:43 A M Shirley Marian Parker Johnson /Medical 4a. Facility Name (II not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cecil Union Hospital of Cecil County Elkton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. (Month, Day 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 X F 1935 Virginia 72 Nov. Director 219-30-0281 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits wohe! Peges 1 and 2 should be filed within 72 hours after death with the Maryla ment of Heelth and Mental Hygiene.

ant: If Item 27 is marked other than "naturel", or iteme 23a or 28e-f ehov ury or other traumatic event, If a Medical Examinat must be indified at 1 ☐ Yes 2 No Directo Maryland Cecil Elkton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21921 U.S.A. 500 Skipjack Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 🔏 No Specify: White Specify: If Yes, Give Year or Dates: Completed by 3 ☐ Widowed 4 Divorced 15. Decedent's Education
(Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Civil Service Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Robert Parker Hortense Clara Kerr ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Johnson (Son) 6 Lansdown Ct. Elkton. MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of Important: If any injury or Injury or Angel Hill Cemetery 3/6/2008 Havre de Grace, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. ature of Funeral Service Licensee 123 S. Washington St. Havre de Grace. MD 21078 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac Tr respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending philor in the second IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 20 No 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to comptetion of cause of death? certificete has blirector, page 2 s autopsy performed 1 ☐ Yes 1 Tyes Hospitel or Attending Physicien: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 🗌 Inpatient P/Outpatient 3□ DOA this s after death.
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id in by the funeral d 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural Division 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical within 2 To the 29b. Signature and title dertifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person wi completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, 32. Registrar's Signature State Registrar

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth 3. Time of Death Month Day Year **Physician** LISSA DERRY KEPPLER 26,2008 February 2345 /Medical 4e Fecility Name (If not institution, give street end number) 4b Cify Town or Location of Death 4c. County of Death Examiner Garrett County Memorial Hospital Garrett Oakland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1□M 2X F 63 312-46-5111 Director 10/26/1944 Indiana Usuel Residence of Decedent death with the Marylend 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits me 23a or 28a-f ahor WV Preston Terra Alta 1 ☐ Yes 2 ☐ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 26764 U.S. 279 Clover Drive Funeral Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Heme 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status filed within 72 hours after 1 Never Merried 27 Married 1 ☐ Yes 2 【No If Yes, Give Saltimore, Maryland 21215-0020 5 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Year or Detes: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. than Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental | Richard Alfred Derry Dean Rogers Derry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) it of Health a 279 Clover Drive, Terra Alta, WV Franz Keppler 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2☐Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ō Department of Important: If 2/28/08 Morgantown, Injury Omega Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Arthur H. Wright Funeral Home 26764 WV Katherine 105 Highland Avenue, Terra Alta, 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Respirator Examiner Physician/Medical Examiner ed by the attending physicien end datached for use es the buriel-trensit Attending Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1⊠Yes 2□ No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy s after death.

s after death.

a Director: After this certificate he TLIYOS SLINO 1 □ Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2□ Accident investigation filled in by tha 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 6 within 24 hours a To the Funeral D To the Hospital 29a. Certifier edical Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. Σ 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) Ulle 30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) Md. 31. Date filed (N 32. Registrer's Signature State Registrar

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A Marie A	2		30. Name and address of p	erson who			3a) (Type,						
- The second	2		30. Name and address of p		completed cause of de	eath (Item 2	Fa115			lle, pa	,2,3		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 28, 2008 **Physician** Paulina 2:15 a<sup>M</sup> Koger February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Clinton Nursing and Rehab Clinton Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 1 / 1 7 1 □ M 2 🕱 F Months Days Hours 72 Yrs Director 214-34-6541 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10d. Inside City Limits 10h County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 XYes 2 □ No Director Temple Hills Maryland Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3508 Summit Drive 20748 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 2 should be filed within 72 hours after a nand Mental Hygiene. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify. Specify:BLACK 3 Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Safeway Associate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Hawkins Tolson Josephine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5716 Linda Lane Camp Spring, Maryland 20748 Eric Koger/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 3/6/08 Cheltenham, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Adams Funeral Home PA 20605 Aquasco Rd. Aquasco, Maryland 20608 23a. Part1. Enter tife disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myo Candia **Physician** my disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Rectal Comce Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine EN Cephalo Path that the death certificate be executed and Due to (or as a consequence of): Box 68760. Bacternia Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Munknown Completed ulca 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA P 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28d. Describe how injury occurred Injury at Work? Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

29d. Date signed (Month. Dav. Year)

			1 - For State Registrar	State of Ma		artment of rtificate of		nd Mental Hy	giene Reg. No.	08	08445	
	Physic	ian	Decedent's Name (First, Middle, La  T					2. Date of De Month	ath	Year	3. Time of Death	
	/Medi Exami		Lyman  4a. Facility Name (If not institution, giv  Charlotte Hall V		Kissele ne	4b. City, Town,	or Location of		4c. Count	2008 y of Death Mary	3:04P M	
	Funeral Director		5. Social Security Number 6. S 577-28-5195	ex 7. Age	(In yrs. last birthday) 85 Yrs.	If Under 1 Yea Months Day	r If Under 24 s Hours	Hrs. 8. Date of Bir Min. (Month, Da November 4	th v. Year)	9. Birtho	place (State or Foreign ntry) rginia	
	be filed within 72 hours after deeth with the Maryland lat Hygiene. d other than "natural", or iteme 23s or 28s-f show event, the Medical Exeminar must be conflided at	Funeral Director	10a. State 10b. County  MD St. Mar  10e. Street and Number  29449 Charlotte	y's	10c. City, Town or Lo	te Hall	0622		10g. Citizen of		10d. Inside City Limits 1 □ Yes 2 No	
5-0036	72 hours after dee natural', or iteme alcal Examinar m	þ	11. Marital Status  1. Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's E.	12. Was Decedent Ever in U.S. Amped Forces?   1								
12121	filed within Hygiene.	Completed										
ryland	2 should be tand Mental his marked of aumatic ever	To Be	Morris Kisseleff  19a. Informant's Name/Relationship		105 145		Este	elle Botkin	n			
Baltimore, Maryland 21215-0036	es 1 and 2 of Heelth a litem 27 is rother tra		Ruth Ladd/Sister  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Demoved from State	20b. Place of Disponsional Company Company	Tan 1ew	ood Dri	or Rural Route Number Lve , Warrent Date 3/1/2008	20c. Location	2018	7 own, State	
Ball	permit. Page Department Important: if any injury or		21. Signature of Funeral Service Licen	hus		211 St.	Mary's	FUNERAL HO	Lata,MD	2064	46	
A.	Physician /Medical Examiner	miner	23a. Part1. Enter the disease, or composed in the composition of the composition of the composition of the composition of the cause of the composition of the cause. Enter Underlying Cause, (Disease or injury)	a		er the mode of dy	ing, such as ca	My T	rrest,		Approximate Interval Between Onset and Death	
68760,	rificate be executed og physicien end as the burial-transit	Medical Examiner	that initiated events resulting in death) Last	cDue to (or as a d								
P.O. Box	The law requires that the death certific lie has been signed by the attending p rage 2 should be detached for use as	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	су			23d. Date of delivery Month Day Year		
	w requires that been signed I should be det	eted by P	Part II. Other significant conditions of	ontributing to defath but	not Bulting in the ur	derlying cause g	iven in Part I.				ne cause of death?	
Division of Vital Records,		e Completed	Dlm en 25. Was case referred to medical	Fig.				1 Yes	rmed?	prior to con death?	psy findings available impletion of cause of 2 No	
Ž	hysicia his cert I direct	To Be	examiner?	Hospital: 1 ☐Inpatient	2 ER/Outpatien	t 3 DOA	han /	Death Check only o		ner (Specify		
ision c	ittending death. stor: Afte / the fune	Certification:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be	-			]Yes 2∏No		now injury occur			
Ω	Hospital or A 4 hours after Funeral Directely filled in by	al Certif	4 Homicide determined  29a. Certifier Certifying Phy	building, etc.				City or Tox	vn, State)		I Route Number,	
•	To the Hos within 24 h To the Fur completely	Medical	29b. Signature and title of certifier.	iner. On the basis of ea and manner state	xamınation and/or inv	estigation, in my	se number	occurred at the time,	date and place,	and due to	the cause(s)	
1	8781		30. Name and draw person who Dr. Calleryty, M.D.	pleted cause of deal 29449 Cha			Charlot	te Hall,MD	20622	20/	00	
190	Sta Registr		31. Date filed (Month, Day, Year)  MAR 0 3	32. Registrar's	Signature	barle						

				artment of Health and Mental Hygiene ortificate of Death
8	Dharia	Se	1. Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
	Physici /Medi		Madison Alexis Klinger	March 9, 2008 12:25a M
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
		,	Union Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	E1kton Cecil  If Under 1 Year   If Under 24 Hrs.   8 Date of Birth   9 Birthsloop (State of Early)
Н	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2℃ F 7. Age (In yrs. last birthday Yrs.	Months Days Hours Min. (Month, Day, Year)
	15. 100		Usual Residence of Decedent	1 March 8,2008 MD
	nylano how at		10a. State 10b. County 10c. City, Town or L	ocation 10d. Inside City Limits
	e Ma 3a-f s tiffied	cto	MD Cecil Rising	g Sun 1 □Yes 🛣 No
	or 28	Dire	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	s 23a	eral	107 Douglas Ct.	21911 U.S.A.
Maryland 21215-0036	Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1□ Yes 2♥ No Specify:  14. Race - American Indian, Black, White, etc.  Specify: White
2-0	72 ho natur lical	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working  16b. Kind of Business/Industry
2	rithin ne. han "	mple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)
2	iled w lygiei ther ti	S	17. Father's Name ( <i>First, Middle, Last</i> )	
and	d be f ental i	Be C	Braden Klinger	18. Mother's Name (First, Middle, Maiden Surname)
<u>Z</u>	shoul nd Me mark imati	은		Jana Dang  ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Š	s 1 and 2. of Health a item 27 is			7 Douglas Ct., Rising Sun, MD 21911
Jre,	ss 1 a of Hea item		20a. Method of Disposition 20b. Place of Disposition	osition (Name of Date 20c. Location - City or Town, State
altimore,	Page nent c int: If			erris Inc. March 12, 2008 West Chester, PA
alt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee 2	2. Name and Address of Facility
m	20 E % 5		A Collec	Andrew G. Gee Funeral Home
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	259 E. Main St. Filkton MD approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Pram Granty	Onset and Death
	/Medical Examiner		Due to (or as a consequence of :	
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	
oʻ	exec an and rial-tra		resulting in death) Last  Due to (or as a consequence of):	
8760,	icate be executed physician and s the burial-transit	dical	d	
39	ng ph	Med	IF FEMALE:	
D. Box	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy 23d. Date of delivery Other (specify) Month Day Year
р. О	that the ed by detac		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
Hecords,	w requires that the d been signed by the should be detached	Completed by	Maternal Rustward Appendix	
			Acute Abdomen	24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No
VITal	Physician: this certific al director,	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (Check only one)  Other: ACI Number of Death (Check only one)
ō	Phy er this eral di	2	1 ☐ Yes 2 ☐ No	4 Nursing Home 5 Residence 6 LiOther (Specify)
0	ndlng th. r: Afte e fune	tio	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation (Month, Day Year)	28c. Injury at Work?  M 1 □ Yes 2 □ No
UIVISION	Atter	ifica	3 ☐ Suicide 6 ☐ Could not be	eet, factory, office 28f. Location (Street and Number or Rural Route Number,
5	tal or s afte al Dir ed in	Certification:	4 Homicide building, etc. (Specify)	City or Town, State)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical (	29a. Certifier (Check only one)  1 ⚠ Certifying Physician: To the best of my knowledge, deatled the control of	n occurred at the time, date and place, and due to the cause(s) and manner as stated.  vestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To To I	Σ	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
•				H 0057801 03-11-08
	0		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)
	Stat	ie.	31. Date filed (Month, Day, Year) a 32. Registrar's Signature	Elkon no 21921
	Registra		MAR 1 2 2008 Been &	

State Registrar Delboy

32 Registrar's Signature

Frederick

31. Date filed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			i icasc i	State of Maryla				-	ane Legible.	
			1 - For Stete Registrar	State of Maryla		rtificate of i			- 21111X	08452
			Decedent's Name (First, Middle, Last)			timodito or i	Douth	2. Date of Death	g. No.	3. Time of Death
	Physic		JAME S KE	mard				Month 3	Day Year	
a distribution	/Medi Examir		4a. Facility Name (If not institution, give s		<del></del>	4b. City, Town, or	r Location of Deatl		4c. County of De	
			Chestertown nursing &	Rehabilitation	n center	Chestee	Lown		TENT	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	rthplace (Stete or Foreign Country)
	Director		185-20-7378	IVI ZUGET	96 Yrs.			1 1	1912	(cm)
	land w		Usuel Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Mary -1 sh	ρ	mo Queen an	067 68	ntrevi	ule.				1 Yes 2 No
	r 28e	Director	10e. Street and Number	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		10f. Zip Code		10	g. Citizen of What C	Country?
	739 o	a D	104 Tilghman	QuE.		2161	7		USA	
	ems erms	ner		2. Was Decedent Ever in Armed Forces?	U.S. 13. \	Was Decedent of Hi f Yes, specify Cuba		pecify Yes or No-	14. Race - Am Black, Wh	
92	or le	F	1 ☑ Never Married 2 ☐ Married	1 ☐ Yes 2 ☑ No If Yes, Give	- (	1 ☐ Yes 2 ☑ No	Specify:	o - noan, o.c.,	Specify:	ne, etc.
21215-0036	tiled within 72 hours after death with the Maryland Hygiene. ther than "neturel", or Items 23e or 28e-f show ant, the Medical Exacilinat must be profitted at	Completed by Funeral	3 Widowed 4 Divorced	Year or Dates:					E	plack
7	"net	lete	15. Decedent's Educ (Specify only highest grade		16a. Deced	lent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wor	rking	6b. Kind of Busines	s/Industry
7	withii ene.	m C	Elementary/Secondary (0-12)	College (1-4or 5+)					RC A	
2	Hygi Hygi other ent,	Be C	17. Father's Name (First, Middle, Last)	*	FAC	7 000	18. Mother's Nan	ne (First, Middle, M	aiden Sumame)	*****
삘	ic ev	To B	John Kennar	cd			Elias	beth Jo	chasan	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or Items 23e or 28e-f show any injury or other traumatic event, I'm Medical Examiner must be notified at ance.	_	19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street a	and Number or Ru	ral Route Number,	Shn Son City or Town, State,	Zip Code)
Σ	and 2		Lawrence white-Gi	CU3 MAJOR TAST	11068	Lupsal S	ST. Philo	adelphia	PA 19150	2
Baltimore,	es 1 a of He fiterr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re		Place of Dispo-	sition (Name of netory or other plac			0c. Location - City o	
Ĕ	Pag ment ant: J ury o		'4 □Donation 5 □Other (Specify)	en State	manue	Lu.m.	3-5	5.2008	Pomona, WALLEY T	MD
<u>=</u>	permit. Depart Import any inj		21. Signature of Funeral Service License		22	. Name and Addres	s of Facility	enneth	F Y311AW	uneral
_	205 2 9		Jusce V. Walle	ery (woo	026)15	RUICE BZI	Wist a	nnapolis	IND ZI	+01
			23 a rart1. Emer the disease, or complic shock, or heart failure. List only one	e cause on each line.				or respiratory arres	st,	Approximate Interval Between
1	Physician	3	Immediate Cause (Final disease or condition	Alzhei	WOVS	Dement	19			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):					100
н	Examine		Sequentially list conditions, b.							
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence or):					
_	xecut and Il-trar	xan	that initiated events c. resulting in death) Last	Due to (or as a conse	quence of):					
760,	ate be executed hysician and the burial-transit	cai E		·	,					
	tificate ng phys as the		d.							
Вох	death certifica e attending ph d for use as ti	Š	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregn					23d. Date of de	alivery
m	at the death certi I by the attending stached for use a	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fet 4 Pregnant at time of		Ectopic pregnancy Other (specify)			Month	Day Year
0	t the by th	hys	9 🗍 Unknown	9□ Unknown					- Renaulation	
'n.	The law requires that the tee has been signed by thoage 2 should be detache	Completed by Physician/Med	Part II. Other significent conditions cont			derlying cause give	en in Part I.	23e. Did toba	cco use contribute	o the cause of death?
Ë	w require been si should b	b	KTN: HX CHF	: Arthviti	5			1 ☐ Yes	2 No 3 P	robably 4. Unknown
ပ္ထ	law re as be 2 sho	plet						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
	The ate h	ĕ						performe	ed?   death?	s 2 No
Vital Records,	Physicien: The law this certificate has I ral director, page 2 s	Be (	25. Was case referred to medical examiner?					th (Check only one)		
	Physic this c	ဥ	1 165 24 NO		ER/Outpatient		432 Nursing H		ce 6 ☐Other (Spe	ecify)
Ę.	ding P	on:	27. Manner of Death 12√2 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	:?	28d. Describe how	injury occurred	
Division of	ottendii death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	CO. Disea of laine. At h			res 2 □ No	OR Leasting (Ctra	et and Number or R	lumi Pouto Numbos
2	of or Attency after death Director: d in by the	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy)	et, factory, office		City or Town,	State)	urai noute Number,
_	Hospitel or Attending 24 hours after death. Funeral Director: After tely filled in by the fune		29a. Certifier 102 Certifylna Physi	cian: To the best of my kn	owledge death	accurred at the tim	e date and place	and due to the cau	sea(s) and manner a	e stated
	To the Hospitel within 24 hours a To the Funeral [ completely filled	Medical	(Check only 2 Medical Exemine	er: On the basis of examination and manner stated.	ation and/or inv	estigation, in my op	inion, death occur	rred at the time, dat	e and place, and du	e to the cause(s)
	roth Mithin Compl	Me	29b. Signature and title of certifier			29c. License	number	290	d. Date signed (Mon	th, Day, Year)
			100 x 2000	3		D 005	50996		03/04/2	007
	1	-	30. Name and address of person who com	npleted cause of death (Ite	m 23a) (Type, F				-1-11-	7 0 il (1 A
	m		Neil Stoddam	MDIO	1700	wn St	- Unes	sterto	wnn	D21620
	Sta		31. Date filed (Month, Day, Year)	32. Regist r's Sign	ature	1 -				
	Registra	ar	MAR 0 4	2008	0 1	STORE !				

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar		State (	Ji iviai yia		rtificate of	Death	vientai Hy	Reg. No.	18	08453
	Physic	ian	1. Decedent's Nar	ne (First, Middi						2. Date of De Month	Day Y	'ear	3. Time of Death
	/Medi	cal	4a Facility Name	(If not institution	n, give street and nu	elen Mari	ie Loar	4h City Town o	or Location of Death		1arch 01, 200		12:25 P.
	Examí	ner	4a. I acility Name		le Nursing an	,	Center	4b. City, Town, o			4c. County of		egany
	Funeral		5. Social Security		6. Sex		s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	th s	Di-th1-	- (0)
	Director			76-7916	1□M 2 <b>X</b> F	8	33 Yrs.	Months Days	Hours Min.		nber 08, 1924	Countr	Maryland
	and w		Usual Residence of 10a. State	of Decedent 10b. County		10c. (	City, Town or Lo	cation					d. Inside City Limits
	Mary -f sho ied a	Þ	Maryland	d	Allegany				Lonaconin	n			1 X Yes 2 □ No
	with the Maryland a or 28a-f show be notified at	Director	10e. Street and No		1 moguny			10f. Zip Code	Lonacomin	5	10g. Citizen of Wha	at Countr	y?
	death wit				7 Jackson St	reet			21539			U.S.	.A.
	ter des items ner m	Funeral	11. Marital Status		Armed F		U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Race - Black,	Americar White, et	
36	ours after or ral", or iten Examiner	by F		rried 2 Mar 4 Divorced	If Yes G			1 ☐ Yes 2 🗖 No	Specify:		Specify:		W/h:40
21215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at	ted	(0.	15. Deceder	t's Education		16a. Dece	dent's Usual Occup	pation		16b. Kind of Busin	ness/Indu	White
215	within 7 ene. <b>than "r</b> he Med	Be Completed	Elementary/Sec		st grade completed, College (	(1-4or 5+)	life.	NOT use retired	during most of word d)	king			
21	led wi lygier her th	S	42.5 % 1.11	8		0			Homemaker			Но	me
Maryland	should be filed very tod Mental Hygies marked other tumatic event, the	Be	17. Father's Name	(First, Miadie,	,	Russell			18. Mother's Nam	ne (First, Middle	, Maiden Surname) Lena Clark		
Z	shoule nd Me mark imatic	은	19a. Informant's N			Russell	19b. Mailir	na Address (Street	and Number or Ru	ral Route Numb	er, City or Town, Sta	ate Zin C	(ade)
	and 2 salth ar 27 is			David	l Loar - Son						naconing, Ma		
ore	es 1 a of He fitem		20a. Method of Dis		3 □Removal from		. Place of Dispo	sition (Name of natory or other place	ce)	Date March 04,	20c. Location - Cit	ty or Tow	n, State
Ĕ	. Pag tment tant: I		4 ☐ Donation	5 Other (S	Specify)	State		el Hill Ceme		2008			s, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any injury or other traumatic event, the Medical once.		21. Signature of F	uneral Service	Licensee		22	Name and Addre	Eichnorn-M	cKenzie F	uneral Home ning, Marylar	P.A.	530
			23a. Parti. Enter	the disease, or	complications that	caused the de	ath. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	F	Approximate nterval Between
60	Physician		Immediate Cause disease or condition	on	. M	40cAR	DIAL Z	NFARATR	»~				Donset and Death
	/Medical Examiner		resulting in death)				equence of):						
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	uted d ansit	min	if any, leading to in cause. Enter Und Cause (Disease of that initiated event	erlying r injury		(01 23 2 001130	squerice oi).						1 /
ó	exection and rial-tra	Examiner	resulting in death)	Last	cDue to	(or as a conse	equence of):						
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	ertifica ling pt e as t	Med	IF FEMALE:		T								
Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was deceder in the past 12	2 months?		itcome pf preg birth 2□Fe nant at time of	tal death 3	Ectopic pregnancy	4		23d. Date of	,	ay Year
0	the de	ysic	1 ☐ Yes 2· 9 ☐ Unknowi		9□Unkr		death 5L	Other (specify)					,
О.	s that ned b	by Ph	Part II. Other sign	ificant condition	ons contributing to d	eath but not re	esulting in the ur	nderlying cause giv	en in Part I.	23e. Did t	obacco use contribu	ite to the	cause of death?
Records,	w require been sig should be	ed b	Co	HGESTI	VE HEA	RTFA	NU PE			1 🗆 '	Yes 2 No 3[	☐ Probab	oly 4 🗖 Inknown
ecc	law re as be 2 sho	Completed								24a. Was	an 24b. We	re autops	y findings available pletion of cause of
<u>E</u>	The law cate has I page 2 s	Com								perfo	rmed? dea	th? Yes 2	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case refe examiner?		Hospital:			0.45	26. Place of Deat				
ō	Phys this ral dir	<u>구</u>	1 ☐ Yes 2 ☐ 27. Manner of Dea		28a. Date		☐ ER/Outpatien 28b. Time of		4 Mursing H		dence 6 Other (	(Specify)	
on	Attending Phyrr death. ector: After thi	tion	1 ☑Natural 2 ☐ Accident	5 Pendin	g (Mor	th, Day Year)	Injury	28c. Injur Worl	k? Yes 2 □ No	200. Describe	low injury occurred		
Division	or Attendate death Director: in by the	ifice	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could r determ	inod 28e. Place	of injury - At ing, etc. (Spec	home, farm, stre	eet, factory, office		28f. Location (	Street and Number of	or Rural F	Route Number,
Ö	ital or rs afte ral Dir led in	Certification:			4					City or Tov			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical	29a. Certifier (Check only one)	1 ☐ Certifyin 2 ☐ Medical	Examiner: On the b	e best of my kr easis of examinated.	nowledge, death nation and/or inv	occurred at the tir restigation, in my o	ne, date and place, prinion, death occur	and due to the red at the time,	cause(s) and mann- date and place, and	er as stat d due to ti	ed. he cause(s)
	To the within To the comp	Me	29b. Signature and	title of certifie	1			29c. License			29d. Date signed (A	Month, Da	ay, Year)
			<b>•</b>	He	Vhur			126	907	1	MARCH 3	200	S
		5	30. Name and add		who completed caus	se of death (Ite			mberia		ND DIS	573	
	Sta	_	31. Date filed (Mor			agistrar's Sigr		- 00		-//	201	300	
	Registr	ar		MAR -	2 TANO	ProBacco n	B. A	and a					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 28 4:23p 2008 Sanghe Lyu February 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 11603 Pindell Woods Drive Fulton Howard Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Months Days Hours Min 1 □ M 2 🕅 F 237-22-4759 97 9/28/1910 Seoul, Korea Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 XYes 2 No Maryland Howard **Fulton** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20759 11603 Pindell Woods Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Specify: Korean 1 ☐ Yes 2 【 No 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Librarian

with the Maryland 28a-f show notified at 23a or the Medical Examiner must be death v 'natural", or Items 72 hours after Hygiene. and Mental Hygie is marked other pe permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau

Maryland 21215-0036

Baltimore.

**Physician** 

/Medical

Examiner

10a. State

Elementary/Secondary (0-12)

Tksoo

17. Father's Name (First, Middle, Last)

Hahn

College (1-4or 5+)

Director

Funeral

þ

Completed

Be

ပ

**Funeral** 

Director

**Physician** /Medical Examiner

death certificate be executed

P.O. Box 68760,

Division or Vital Records,

burial-tran physician as þ cate has been si funeral Hospital or Attending P 4 hours after death. Funeral Director: After t

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4886 Denaro Dr., Las Vegas, NV Seung Lyu - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 3/4/2008 Brentwood, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licenses 3401 Bladensburg Rd., Brentwood, MD 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 A No 9 ☐ Unknown 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: ome 5 Residence 6 □Other (Specify)
28d. Describe how injury occurred 2[**X**No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DDA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ∏Yes 2 ∏No M 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

Examiner Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical examiner? Be Certification: To 27. Manner of Death 29a. Certifier Medical

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title

FEBRUARY 28, 2008

University

Month

Day

3 Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Approximate Interval Between Onset and Death

WEEKS

Year

18. Mother's Name (First, Middle, Maiden Surname)

Haesoon Kang

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN, MD 6565 NCHARLES ST. SUITE 209 BALTIMORE. MD 21204

State Registrar

filled in by

within 24 hours a Hospital

the



			1 - State Registrar	Otato or ivit	C	•	ficate of		III IVIC	, ,	Reg. No	2000	08455
ß		Н	1. Decedent's Name (First, Middle, La	st)					2	2. Date of Dea Month	ith Da	y Year	3. Time of Death
	Physicia /Medic		Juanita Daisy	Leake					F	ebruar		7. 2008	7:12 A M
	Examin		4a. Facility Name (If not institution, giv	e street and number)		4	lb. City, Town, o	r Location of	f Death		4c.	. County of Dea	ith
\$50 *			Holy Cross Hosp				Silver	Sprin				ontgome	
	Funeral		Social Security Number     6. S	I⊓M 2□WE	e (In yrs. last birtho	- N	If Under 1 Year  Nonths Days	If Under 2 Hours	Min. 8	Date of Birth (Month, Day	Year)	9. Bir	thplace (State or Foreign ountry)
	Director		577-32-8493 Usual Residence of Decedent		82	٥.			N	lov. 14	, 1	925 Was	hington, DC
	and w		10a. State 10b. County		10c. City, Town o	r Locat	tion						10d. Inside City Limits
	Maryi f sho	0	D:-+-:	2 1 1 1 .	***								1 TyYes 2 □ No
	the   28a- notif	Director	District of (	Jolumbia	Washi	ngt	10f, Zip Code				10a. Cit	izen of What C	ountry?
	3a or	Ö	3101 Sherman Ave	enue NW			20010					ited St	,
	ns 2:	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Wa	is Decedent of H	lispanic Orig	jin? (Speci	fy Yes or No-		14. Race - Am	erican Indian,
0	r iter		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 📉	No				, Puerto Ri	can, etc.)		Black, Whi	te, etc.
3	ours a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 L	Yes 2 No	Specify:			1	Specify: B	1ack
2-0036	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or Items 23a or 28a-f show snt, th. Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a. D	eceder	nt's Usual Occup	ation	of working	,	16b. K	ind of Business	/Industry
V	ithin ne.	uple	Elementary/Secondary (0-12)	College (1-4or 5	/ii	fe. DO	NOT use retired	d)					
V	ed w lygier lygier lt, th	S	12 years		bA	min	istrati					vernmen	t
yıana	be fill	Be	17. Father's Name (First, Middle, Last						•	First, Middle,		i Surname)	
3	Mer Marke Marke	မ	James Francis Ma		1.00					Frankl			
<u> </u>	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship ( Karen D. Pate - I			_	Address (Street						
ď	1 and Health em 2 ther	/	20a. Method of Disposition	augireer					Dat			ocation - City o	
פַ	nt of :: If its		1 ☐ Burial 2 反 Cremation 3 ☐		20b. Place of D cemetery,							•	
baitimor	urtme ortani injury		4 ☐ Donation 5 ☐ Other (Specifical Service Lice)		Lee's		matory Name and Addre			, 2008		Clinton	n, MD
Ď	permit. Pages 1 and 2 Department of Health s Important: If item 27 Is any Injury or other tra once.			(2) MO. V	11-11		01 Benn						
	Salton S		23a. Parl 1. Suter the disease, or com	plications that caused	the death. Do not							scon, D	Approximate interval Between
	Dhysisian	,	show, owheart failure. List only immediate Cause (Final			41	20.0						Onset and Death
	Physician /Medical		disease or condition resulting in death)	_ a	ratory Fa		.re						
	Examiner			Pneumo									
194	A.	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	a consequence of)	:							
	outed Id ansit	Examiner	Cause (Disease or injury that initiated events	CVA									
5 C	an an nial-tr	Ex	resulting in death) Last		a consequence of)	:							
00/00	certificate be executed iding physician and ise as the bunal-transit	Medical	•	Dement	tia								
	# Do in	Med	IF FEMALE:										
Š	ath ce tendi	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	pf pregnancy 2 Petal death	3 □ E	ctopic pregnancy	,				23d. Date of de Month	elivery Day Year
5	e deg	Physician/	1 ☐ Yes 2 ☐ No 9 🖫 Unknown	4□Pregnant at 9□Unknown	t time of death	5 🗆 C	other (specify)					WOTE	Day Tour
ŗ	sician: The law requires that the death cer certificate has been signed by the attendir rector, page 2 should be detached for use	Phy	Part II. Other significant conditions	contributing to death h	ut not resulting in th	a unde	artvina cause aiv	an in Part i		23e Did to	hacco	use contribute t	to the cause of death?
Š	ires t signe	by	DM, HTN, Chroni										Probably 41 Unknown
ecoras,	requ	Completed				, 0	angrene	,					
ב ב	e law has t	nplu.	Peripheral Vasc	ular Disea	ase					24a. Was a autop perfor	sy	24b. Were a prior to death?	utopsy findings available completion of cause of
2	n: Th icate r, pag									1□ Yes	2 No		
VIIa	Physician: r this certifica ral director, I	Be	25. Was case referred to medical examiner?	Hospital:			3□ DOA Oth	Or.		Check only or			
5	Phys r this ral di	<u>유</u>	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of Inju	ent 2 ER/Outpa			7 🗆 1401		e 5 ∐ Resid d. Describe h		6 □Other (Sp	ecify)
VISION	Attending r death. ector: After by the fune	tion	1 X Natural 5 ☐ Pending investigation	(Month, Da	y Year) Inju	ıry	28c. injur Wor M 1 🗆	k? Yes 2∐N			,	,,	
2	Atten deat actor	fica	3 Suicide 6 Could not b	e 28e. Place of init	ury · At home, farm	, street							Rural Route Number,
S	To the Hospital or Attending Phys within 24 hours after death.  )To the Funeral Director: After this completely filled in by the funeral director.	Certification:	4 ☐ Homicide determined	building, et	c. (Specity)					City or Tow	n, State	9)	
	pspita hours mera y fille		29a. Certifier 12 Certifying Ph	nysician: To the best	of my knowledge, o	leath o	ath occurred at the time, date and place, and due to the cause(s) a investigation, in my opinion, death occurred at the time, date and					and manner a	is stated.
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	(Check only 2 Medical Examone)	and manner sta		or inve	stigation, in my o	opinion, deal	th occurred	at the time,	date an	d place, and du	e to the cause(s)
	withi To tl	ž	29b. Signature and title of certifier				29c. Licens	e number		2	29d. Da	ite signed (Mor	th, Day, Year)
)	(3)			seem			D64.	578		1	Febr	cuary 28	3, 2008
	01		30. Name and address of person who	completed cause of d	eath (Item 23a) (Ty	pe, Pri	int)	C = 1	- C		WD 0	20010 1	4.9.4
(	GEX.		Mehmooda Naeem,		00 Forest	GL	en Koad	SILVE	er Spi	ring, I	עני.	20910-14	+04
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature								
	negisti	at	MAR 0 4 2008	Elder	H. Apr								

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kevin R. Lawye		State of 1-For State Registrar	Maryland / Depar Certi	tment of H			g. No.	0 001 5	
Physici Medical Exam	an/	Decedent's Name (First, Middle,Last)				2. Date of Deat		3. Time of Death	
viedicai Exam	mer	Kevin Robert Lawy  4a. Facility Name (if not institution, give st		4b. 0	City, Town, or Location of	Month February 2	1, 2008 4c. County of Death		
		Route 91 North of Deer Park			inksburg		Carroll		
Funeral Director			7. Age (In yrs. las	, N	Under 1 Year If Under fonths Days Hours	Min.		thplace (State or Foreign untry) MD	
any		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Location				10d. Inside City Limits	
* .	_	MD Carro	)]]	inksbur	~			1 Yes 2 X No	
Maryland 28a-f show	Director	10e. Street and Number	1 1	10	f. Zip Code	10	g. Citizen of What Cou	ntry?	
th the l 23a or 10tifie		3931 Benson Mill	Ct		21048		USA		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces?  Yes 2 No	If Yes, s	ecedent of Hispanic Origin specify Cuban, Mexican, I s 2 X No specify:		White, etc.	ican Indian, Black,	
urs aft tural" amine	d by	15. Decedent's Education (Specify only I	Dates:	l6a. Decedent's U	sual Occupation (Give ki		Specify: W 16b. Kind of Business/	hite Industry	
72 hou 12 hou 10 "na	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of	of working life. DO NOT u	se retired)			
003( within iene. er tha Medic	dmo		5+	Orth	nodontist		Private	Practice	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be Co	17. Father's Name (First, Middle, Last) Philip Robert Law	Ner			Name (First, Middle, M			
212 212 213 214 215 215 215 215 215 215 215 215 215 215	To B	19a. Informant's Name/Relationship (Type	-	19b. Mailing Ad	dress (Street and Numb	n Lucille er or Rural Route Num		e, Zip Code)	
MD d 2 sho Ith and In 27 is	ΙÍ	Susan S. Lawyer/wi		3931	Benson Mill	. Ct Finksb	ura. MD 21	048	
nore, MD 2121; ages I and 2 should be fil nt of Health and Mental I nt: If item 27 is marked other traumatic event,		20a. Method of Disposition  1 Burial 2 X Cremation 3		ace of Disposition ematory or other p	(Name of cemetery,	Date	20c. Location - City or	Town, State	
Baltimore, permit. Pages I an Department of Hea Important: If ites		4 Donation 5 Other Specify:	Car	roll Cre	mation, Inc	2/25/2008	Hampstead	I. MD	
Balt permit Depart Impor injury		21. Signature of Coner Service Licensee		22 Name	and Address of Facility tts Funeral				
Physician	Н	23a/ Part I. Enter the disease, or complica	ions that caused the death. E	o not enter the m	Washington	diac or respiratory and	assission next	21157 ate Interval	
/Medical		failure List only one cause on each	<sup>ine.</sup> I <b>tiple Injurie</b> s					Between Onset and Death	
Examiner			to (or as a consequence of):						
		Sequentially list conditions, if any, leading to immediate Due	to (or as a consequence of):						
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60, ate be executed hysician and te burial - transit	ical	UNPENDED	MENDED	_					
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.  The Funeral Director. After this certificate has been signed by the attending physician and repletely filled in by the funeral director, page 2 should be detached for use as the burial - transi		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnal Live birth Pregnant at time of deat	2 Fetal d	eath 3 Ectopic	pregnancy	23d. Date of deliver Month	y Day Year	
Bo he dear	hys		Unknown			Los Bull	1		
P.O. that the	by F	Part II. Other significant conditions co	ntributing to death but not res	ulting in the unde	rlying cause given in Parl		bacco use contribute to		
ords, I	ted	-				24a. Was a		utopsy findings available	
COL	Completed					autop	sy prior to	completion of cause of	
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Vital F ysician: his certifi director,	o Be		oital: 1 Inpatient 2 E	R/Outpatient 3	Othor	panany	Residence 6 V Othe	er: Scene	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the stafter death.  In after death.  In interfor: After this certificate has been signed by the funeral director, page 2 should be deach to	-	27. Manner of Death  1 Natural 5 Pending	(Month Day Year)	28b. Time of Injury 1634 hrs	28c. Injury at Work?	Driver auto a	now injury occurred auto collision		
Division ospital or Attenchours after death neral Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hom (Specify) Major Road	ctory, office building, etc.	28f. Location (S or Town, S Route 91 Nort	28f. Location (Street and Number or Rural Route Number, Ci or Town, State) Route 91 North of Deer Park Rd. , Finksburg, MD			
To the Hosy within 24 hor To the Functional Completely	edical	one) 2 Medical Examiner: Or	To the best of my knowledge the basis of examination and manner stated.		in my opinion, death occ				
WIL	Σ	29b. Signature and title of contifier			29c. License number		29d. Date signed (Mo		
5					O.C.M.E.		February 22, 20	08 	
70		30. Name and address of person who com Mary G. Ripple MD. Deput	pleted cause of death (Item 2 y Chief Medical Exami	•	enn Street, Baltimo	re, MD 21201			
<u></u>	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signature		, , , , , , , , , , , , , , , , , , , ,				
Regis		FEB 2 6 2008	Hogue St.	Soule					
DHMH 17 Rev 1/2	001		•	ORIGINAL		OCME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 7.8 per inf 8878 4-10-08 yt. State of Maryland Plepartment of Health and Mental Hygiene 0 8 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Bonnie Μ. Maxwe11 1:30 AM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Franklin Squar Hospital Rostdalt Baltimore 5. Social Security Number 9. Birthplace (State or Foreign Country)
Washington IY If Under 1 Year If Under 24 Hrs. 6. Sex Age (In yrs, last birthday) 1 □ M 2 🗗 215-62-7599 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Prince George's Maryland Temple Hills 1 Yes WNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2803 Keith Street 20748 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 🖾 No Specify Specify 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Home 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Robert Simmons Evelvn Estelle Roberts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2803 Keith Street Temple Hills, Maryland 20748 19a. Informant's Name/Relationship (Type. Print) E. Maxwell / Son Leroy 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Edgewater, Maryland 03/11/2008 5 ☐ Other (Specify) 4 □ Donatio 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signatur Funeral-Service License al 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ardismyopathy Due to (or as a consequence of): TYLES | SERSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last debuiking procedure Ovarian cancer Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Nnknown 1 Tes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autonsy performed? (es 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manyer of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certil 29d. Date signed (Month, Day, Year)

68760, P.O. Box Division or Vital Records,

certificate be executed and

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Completed

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Certification:

Medical

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

is marked other than

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, i

**Physician** 

Examiner

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Baltimore, Maryland 21215-0036

Maxwell, Bonn

attending physician the signed by has certificate Hospital or Attending Physician: this : After thi within 24 hours aren common to the Funeral Director: Aff

State Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) MAR 1 7 2008

Safal Shetty

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000



Franklin

Square

RESOCODO

Drive Baltimore MD 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Vear MARLENE **JEAN** MICHAEL 20:12 /Medical 03 03 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY 7. Age (In yrs. last birthday) 70 Yrs. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 15 1937 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕅 F Director 215-44-8878 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at Allegany Cumberland mD. Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ō pe 701 Furnace St., Apt. 333 21502 United States items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 23€21√No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 "natural", or white 1 ☐ Yes 2000No þ Specify: 3 ☐ Widowed 4 ☐ Divorced er than "nature the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housework Homemaker 10 7 Is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown Mary Frances Jones ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra 604 East Oak St, Oakland, Maryland Steven Michael/ son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/06/ Cumberland Crematory Cumberland Maryland 2008 22. Name and Address of Facility 21. Signature of Funer Service Licensee Boal Funeral Home 111 Church St., Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 3 HOURS a ASPINATION PNEUMONIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an Were autopsy findings available prior to completion of cause of certificate has page 2 autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To this funeral Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Matural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death | Director; 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Hospital of hours af To the Funeral

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Vik Poonai, M.D.



924Seton Dr.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D36766

Cumberland, MD 21502

29d. Date signed (Month, Dav. Year)

March

,2008

State

onth. Day.

29b. Signature

30. Name and ade

29d. Date signed Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Eugene CALVIN MILLER 03 02 2008 2041 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS - BRADDOCK CAMPUS CUMBERLAND ALLEGANY CUMBERLAND

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. Dec. 15, 1927 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 80 Months Mary Land 216-22-7013 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Allegany Frostburg MD. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21532 United States 13520 Old Legislative Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2√2√No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married white 3altimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: þ 3℃Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Paper Manufacturer Chlorine Dioxide Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward S. Miller Mary Della O'Neil ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) is 1 and 2 soft Health and Item 27 is P.O. Box 197, Augusta, West Virginia Roger Miller/son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Frostburg Mem. Park 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or otl
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Frostburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee 111 Church St., Westernport, Maryland 21562 Wayne Sa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** acuto myourted disease or condition resulting in death) hauns /Medical Due to (or as a consequence of): **Examiner** Cormon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) 9□Unknown this certificate has been signed by all director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 66 mutico 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Gaknown Completed Rem acent 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Discret. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: i ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 | Yes -2 | No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 021244

Registrar

State

street

Frostburg

Broadwa

mistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR - 4 2008

DR. JESUS 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. APPN TIPM/29d, per Phys. 68/8,4717/8, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Veal **Physician** 8:00 am ٧. McAllister 27, 02 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Brooke Grove Nursing & Rehab. Ctr. Sandy Springs Montgomery 5. Social Security Number Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Unde Hours **Funeral** 1□M 2▼F Months Days Min. Director 10/28/1911 Washington, DC 577-36-6777 96 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1312 Wembrough Court 20905 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🏝 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Account Manager Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental Garrow E. Veirs Martha Eva Bryant မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Health atem 27 ls Gloria Markward/Daughter 1312 Wembrough Ct., Silver Spring, MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages
Department of i
Important: If it
any Injury or o
once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 03/03/08 Brentwood, MD 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. coltan 3401 Bladensburg Road Brentwood, MD 20722 Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) Cerebrovascular Accident /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of) ding physician The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔼 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> <u>Advanced Dementia</u> 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Gastrointestional Bleed 24a. Was an page 2 s autopsy certificate 2**K** No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2X No P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the Funeral Director: ppletely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08 MO notuno

State Registrar

Box 68760

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Division or Vital Records.

DHMH 17 Rev 1/2001

18111 Prince Philip Drive Olney, MD

20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 0 4 2008

32. Registrar's Signature

Ata Motamedi, MD 31. Date filed (Month, Day, Year)

			For State Registrar	State of Mai	ryland /		artment of H		_	gien Reg. N	/ 111125	081	+62
П		- 1	Decedent's Name (First, Middle, L.)	.ast)					2. Date of De	eath		3. Time of	Death
	Physici /Medio		MICHAEL F. MESSI	TTE					Month MARCH		ay Year 2008	4:10	a <sup>M</sup>
	Examir		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, or	Location of De	eath		c. County of Death		
سيود .	an film of many	ш	CASEY HOUSE				ROCKVILI				MONTGOMER		
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	tems	nue	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. \	Was Decedent of Hi If ∀es, specify Cuba	ispanic Origin? ın, Mexican, Pu	(Specify Yes or No lerto Rican, etc.)	D-	14. Race - Americ Black, White,		
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<b>2-003</b>	thour stural		15. Decedent's	Total of Dates.		a. Deced	dent's Usual Occupa	ation		16b.	Kind of Business/Ind	dustry	
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7	filed within Hygiene. ther than " int, the Me	Completed	Lienteriary/Secondary (0-12)	5+	′ I	TTOR	NEY			RE	LATIONS B	OARD	
and	eve eve	Be	17. Father's Name (First, Middle, Last)  JESSE BLEICH MESSITTE  18. Mother's Name EDITH WE						lame (First, Middle WECHSLER		n Surname)		
<u> </u>	s 1 and 2 should be f Health and Menta item 27 Is marked o other traumatic ev	은	19a. Informant's Name/Relationship	(Type. Print)	19	9b. Mailin	ng Address (Street a	and Number or	Rural Route Numb	er, City	or Town, State, Zip	Code)	
M	nd 2 alth a 27 Is r trau		JUDITH C. MESSIT	re - wife						-	ILLE, MAR	,	2085
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baltimoi	Pages nent of int: If its iry or o	10	1 Burial 2 ☐ Cremation 3: 4 ☐ Donation 5 ☐ Other (Spec		1	-	D MEML GE		02/2008	FAL	LS CHURCH	, VIRO	GINIA
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			23a. Part1. Enter the disease, or conshock, or heart failure. List onl	mplications that caused the y one cause on each line	he death. De	o not ent	er the mode of dyin	g, such as card	liac or respiratory a	arrest,		Approximat Interval Bet Onset and	e ween Death
F	hysician	É	Immediate Cause (Final disease or condition resulting in death)	<sub>a.</sub> Multipl								- Chisci and	
	/Medical Examiner		and the second second	Due to (or as a	consequenc	e of):							
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Ď	be executed ician and burial-transit	Еха	resulting in death) Last	Due to (or as a	consequenc	e of):	**						
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ם ב	ath cath cather	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf	Fetal dea		Ectopic pregnancy				23d. Date of delive Month		Year
5	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tii 9□Unknown	me of death	5	Other (specify)					,	
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2	aw rei	Completed							24a, Was		24b. Were auto	psy findings	available
ב ו	te ha	E O								ormed?	death?	mpletion of c 2□ No	ause of
<u> </u>	ian; irtifica itor, p	BeC	25. Was case referred to medical					26. Place of D	1□ Yes Death <i>Check onl</i>	2 <b>★</b> N one	lo   Times	2   NO	
5 6	nysic nis ce I direc	To	examiner? 1 ☐ Yes 2 ሺ No	Hospital: 1 ☐ Inpatient	t 2□ER/0	Outpatien	t 3 DOA Othe	er: 4 🗆 Nursing	Home 5 ☐ Res	idence	6XOther (Specif	y) Hosp	ice
- i	Ing P		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day )		. Time of Injury	Work	at	28d. Describe	how inju	ury occurred		
2	tend leath. tor: / the fi	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	he -				res 2 □ No	=0				
2	al or A s after of al Direct ed in by	Certification:	4 ☐ Homicide determined		(Specify)	rarm, stre	et, factory, office		28f. Location ( City or To	Street a wn, Sta	and Number or Rura te)	il Route Nun	nber,
	To the rospital of Attending Prhysician: The law requires that the death certified within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending pheometery filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the complete of the control of t	Medical (	29a. Certifier (Check only one)  1 □ XCertifying P 2 □ Medical Exe	Physician: To the best of aminer: On the basis of e	examination a	ge, death and/or inv	occurred at the time vestigation, in my of	ne, date and pla pinion, death o	ace, and due to the courred at the time	cause( , date a	s) and manner as s nd place, and due to	tated. the cause(	s)
F	withi To to	Ź	29b. Signature and title of certifier	10			29c. License	number		29d. D	ate signed (Month,	Day, Year)	
	14		grange like	(dustr v)			D64615	5		larc	h 1, 2008		
	7		30. Name and address of person who						.1		00050		
	-01-		Genevieve Anne W 31. Date filed (Month, Day, Year)	roblewski, N			icard Dri	Lve Ko	ckville,	MD	20850		
	Sta	ıe	or: Date filed (Mentil, Day, Teal)	2008	_ o.griduid	K 1	Topas I						

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of	Marylan	-	artment of rtificate o			-	giene Reg. No.	00	08463		
	Physici	an	Decedent's Name (First, Midd							2. Date of Dea		Year	3. Time of Death		
è	/Medic	cal	4a. Facility Name (If not institution	Mange			4b City Tour	n, or Location	of Dooth	2	4c. County	08	1:40PM		
	Examin	ier	Carroll Luther		,	Ctr		tminste				rrol]			
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Ye	ar II Under	24 Hrs.	8. Date of Birt	h		lace (State or Foreign		
	Director		213-09-5358	1 □ M 2 □ <b>X</b> F	97	Yrs.	Months Da	ys Hours	Min.	June 11		Cour	MD		
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits		
	deeth with the Maryland ma 23a or 28a-f ahow must be coeffind at	ţō	MD C	arroll		Westr	ninster						1⊠Yes 2□No		
	or 28,	Director	10e. Street and Number				10f. Zip Cod	е			10g. Citizen of \	What Coun	itry?		
	eth w		300 St. Luke					21158			USA				
	items	by Funeral	11. Marital Status  1 □ Never Married 2 □ Mar	12. Was Deced Armed Ford ried 1 ☐ Yes	ces?	S. 13. \	Was Decedent of Yes, specify C	of Hispanic Or Suban, Mexical	rigin? (Spe n, Puerto P	cify Yes or No- Rican, etc.)	- 14. Rad Blad	e - Americ ck, White,			
21215-0036	be filed within 72 hours after deeth with the Marylan Hygiene.  d other than "natural", or itama 23a or 28a-f ahow event, the Madical Exam or must be confiled at		3 Widowed 4 □ Divorced	If Yes Give	9		1⊡Yes 2∏x1	No Specify:	:		Specify	v: Wh	nite		
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N	within 72 ene. than "na' he Medic	mple	Elementary/Secondary (0-12)	4or 5+)	life. I	DO NOT use rei	tired)	St Of WORKI	,9						
	filed v Hygie other t ent. In	ပ္ပ	17. Father's Name (First, Middle,	Last)			Seamst		ar's Nama	/First Middle	Man Maiden Suman		uring		
	id be ental ked o	To Be	Ralph Kemp							rmacost		70)			
	should and Men s marke umatic	-	19a. Informant's Name/Relationship (Type, Print)				ng Address (Stre				or, City or Town,	State, Zip	Code)		
E,	and 2 leelth a m 27 ls		Paul Manger/so	n			Lemmon		Westr	ninster	, MD 2	1157			
			20a. Method of Disposition 1 Burial 2 ☐ Cremation	3 □Removal from S		lace of Dispo emetery, cren	sition (Name of natory or other p	olace)	Da	ate	20c. Location -	City or To	wn, State		
	it. Pa rtmen rtant: njury		4 Donation 5 Other (S	Specify)	Kri		JCC Ceme				Westmin		MD		
מ	permit. Pages Department of H Important: If its any injury or of once.		21. Signature of Funeral Service	Licensee							apel, P inster,		21157		
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca	used the death								Approximate		
F	hysician		Immediate Cause (Final disease or condition			Art	on A	* 00	صر کار				Interval Between Onset and Death		
	/Medical Examiner		resulting in death)	Due to (o	r as a conseq	ence of):	0 No		, S C						
	LAdiiiiilei	_	Sequentially list conditions,	b	f as a constant	and the									
	rted nsit	Examiner	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2001010	r as a consequ	refice of j.									
,	execu in and ial-tra	Exar	that initiated events resulting in death) Last	c. Due to (a	r as a consequ	ience of):									
00/0	ite be iysicie ne bur	dlcal		d											
	ing ph	Med	IF FEMALE:												
ָבָּ מ	ath ce	lan/	23b. Was decedent pregnant	ome of pregna th 2 ☐ Fetal	death 3 ☐ Ectopic pregnancy					23d. Date of delivery Month Day					
5	the de	Physician/Me	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	4∐Pregna 9□ Unknov	nt at time of de vn	eath 5	Other (specify)	)			Month Day Year				
	sictant: The law requires that the death certificate be executed certificate has been signed by the attending physicien and rector, page 2 should be detached for use as the burial-transit	by Ph	Part II. Other significant condition	ons contributing to dea	ath but not resu	alting in the ur	nderlying cause	g cause given in Part I. 23e. Did tot				obacco use contribute to the cause of death?			
נטין,	quire;	ed b								1 Yes 2 No 3 Probably 4¥					
ב ב	aw re	plet						24a. Was an					24b. Were autopsy findings available		
	ine iete ha page	Completed								autop perfor 1 Yes	med?	death?	npletion of cause of 2□ No		
) I	cuan: Sertific ector,	Be	25. Was case referred to medica examiner?					Au		Check only or	nel				
5	rhis or ral dir	5	1 Yes 2 No 27. Manner of Death			ER/Outpatien 28b. Time of	3 DUA				ence 6 Oth		0		
5	th. : Afte	tou	1 Natural 5 Pendir 2 Accident investi		Day Year)	Injury		njury at Vork? □ Yes 2 □		ou. Describe n	low injury occur	<del>0</del> 0			
2	ar dea	Certification;	3 Suicide 6 Could 4 Homicide determ	ined 286. Place 0	of Injury - At ho	me, farm, stre	eet, factory, offic	се	2	8f. Location (S	Street and Numb	er or Rura	l Route Number,		
5	rs after or rei Dir	Cer	4-1101110135	Dangang	g, etc. (Specily	, 				City or Tow	m, State)				
	in this hospital or Atlanding Prysician: The lithing 124 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only 21 Medical	g Physician: To the b Examiner: On the bas	is of examinat	wledge, death ion and/or inv	occurred at the estigation, in m	time, date an y opinion, dea	nd place, ar	nd due to the o	ause(s) and ma	nner as st	ated. the cause(s)		
4	ithin 2 o the omple	Med	one) 29b. Signature and title of certifie	and manne	er stated.			ense number	<del></del>		29d. Date signe				
۲	8 - 8 -		) //	//_		_		5217	7		-				
V	N210		30. Name and address of person	who completed cause	of death (Item	23a) (Type, I		12/	-		-/2				
	,		Dr. Tommy ]	Ebrahim	30	5 St	· Luke	Circle	e (	nestr	ninsto	cm	8 1d 21158		
	Stat	te ar	31. Date filed (Month, Day, Year)		girar's Signat		1		,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Month DEAN MARTIN EDDIE 2008 02 28 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death City, Town, or Location of Death Examiner 202 Laird Avenue Somerset If Under 1 Year | If Under 24 Hrs Days | Hours | Min. 8. Date of Birth (Month, Day, Year) June 20, 1947 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months 1 → M 2 □ F 293-38-7424 60 Missiśsippi Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at one. 1 X Yes 2 No Director Maryland Somerset Crisfield 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21817 U.S.A. 202 Laird Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 No 1963— If Yes, Give Year or Dates: 1968 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify. Specify: White Completed by 3 Widowed 4 Divorced 1968 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charlie Martin Ida Lee Walston ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 Laird Avenue - Crisfield, MD Bessie Martin (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buria! 2 X Cremation 3 ☐ Removal from State Salisbury Crematory: 03-04-08 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St.- Crisfield, Robert H. Bradshaw Jr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Physician/Medical Examiner nsequence of) or Attending Physician: The law requires that the death certificate be executed and nsequence of)

Completed by

use as the burial-tran sate has been signed by the attending physician page 2 should be detached for use as the burial certificate has been funeral within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu

After this

Be

Medical Certification: To

Division or Vital Records, P.O. Box 68760,

if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cor
IF FEMALE:	23c. If yes, outcome pf pr

6 ☐ Could not be determined

in the past 12 months?

25. Was case referred to medical examiner?

1 ☐ Yes 2 No

Manner of Death

1 Natural

3 ☐ Suicide

2 Accident

4 ☐ Homicide

9 Unknown

3c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

ncy

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? Yes 2 2 No 1∐ Yes 26. Place of Death (Check only one)

1 Tes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 XNo

Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 5 ☐ Pending investigation

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29b. Signature and title of certifier

2008

00058410

29d. Date signed (Month, Day, Year)

8.0 Box 1737 SAVIS BUNY MD 21802

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COASTAL WAR

HUAM 31. Date filed (Month, Day, Year) State MAR 04

32. Registrar's Signature

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Mar 9, 2008 M 0620 Muia Angelina Teresa /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-Memorial Campus Cumberland Allegany If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 235-30-0207 83 May 4, 1924 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he marting and any 10c. City, Town or Location 10d. Inside City Limits 10a. State ¹¥Yes 2□No MD Allegany Cumberland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10301 Christie Road NE 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 □ Xio Baltimore, Maryland 21215-0036 Specify. Specify: Completed by 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) G.C. Murphy Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jacob Muia Carmela (Argiro) Muia ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 29 Beechwood Drive Cumberland Mick Keller nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State St. Mary's Cemetery 3/12/2008 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Furreral Service Licenses 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final disease or andition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a conse luence of Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a ld be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an cate has b autopsy perform certificate 1□ Yes 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA ျှ 1 Inpatient 2 ER/Outpatient this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 ☐ Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place o injury - At home, farm, street, factory, office holding etc. (Specify) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed I hours after death.

uneral Director: Af
ely filled in by the fur within 24 hours a

To the Funeral C

completely filled the

1 Certifying Physician: To the jest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ماماا و 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D 924 3 32. Registrar's Signature

State Registrar

Medical

31. Date filed (Month, Day,

08-01825

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

aden Anthony Mo	1	- For State Certificate of Death		g. No. 20	08 0846
Physiciar	1/ [	legistrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death	n Year	3. Time of Death
Medical Examin		JADEN ANTHONY MCGEE  4a Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	March 4, 2	4c. County of De	1105 hrs
7	1	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Civista Medical Center  4a. Pata	ı	Charles	au.
Funeral	;		s. 8. Date of Birt	h(MM/DD/YYYY) 9.	Birthplace (State or Foreign
Director	2	212-81-9377   1XM 2 F   Yrs.   Months Days Hours Min	JAN.8	,2008	Country) MARYLAND
		Usual Residence of Decedent			The state of the s
* any	Γ	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits  1 Yes 2 XNo
aryland Sa-f show at once.	₽L	MD PRINCE GEORGE S CAPITOL HEIGHTS  10e Street and Number 10f. Zip Code	140	ng. Citizen of What C	
e Mary or 28a	Director				
ith the	声	1707 QUARTER AVENUE 20743  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	U . S .	A • nerican Indian, Black,
items ust be	-	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		White, etc	<b>.</b>
ili, or ler m		3 Widowed 4 Divorced If yes Sive Year or Dates:		Specify: W	
natura xami		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret		16b. Kind of Busine	ss/Industry
36 n 72 h nan "r	Bet	Elementary/Secondary (0-12) College (1-4 or 5+)		NT / 7	
-00% 1 withi giene. ther the	Completed	0 INFANT  17. Father's Name (First, Middle, Last) 18. Mother's Nam	e (First, Middle, N	Maiden Surname)	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be		A KATH	ERINE MC	GEE
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho rether traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or	Rural Route Nun	nber, City or Town, S	tate, Zip Code)
MD and 2 sho alth and m 27 is aumati	L	TRICIA K. MCGEE/MOTHER 1707 QUARTER AVE.	, CAPI'	TOL HEIG	HTS, MD20743
ore, es l ar of Hee If itel		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  MA			
Baltimore, permit. Pages I an Department of He Important: If ite		4 Donation 5 Other Specify: QUEEN OF PEACE CM. 12	,2008	HELEN,	MARYLAND
Baltimore, MD 2 pernit. Pages I and 2 shoul Department of Health and N Important: If iten 27 is ninjury or other traumarite.	-	2 at ature of Funeral Service Licensee  22. Name and Address of Facility RA  15635 WASHINGTON	YMOND	FUNL.SER	VICE, P.A.
Physician	+	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arm	est, shock, or heart	Approximate Interval
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Sudden unexplained death in infancy			Between Onset and Death
xaminer		or condition resulting in death)  Due to (or as a consequence of):	1		
		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	틢	cause. Enter Underlying Cause (Disease or injury that initiated c.			
\$ \$ d(),	Examine	events resulting in death) Last  Due to (or as a consequence of):			
e be executed ysician and burial - transit	edical	d.			
60, nte be o hysicie		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of del	ivery
68761 certificate nding phy	an/l	23b. Was decedent pregnant in the nast 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregr	nancy	Month	Day Year
Box 6876 e death certificate the attending phy ed for use as the l	Physician/M	4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown g Unknown			
ords, P.O. Box 6876 w requires that the death certificate is been signed by the attending phy should be detached for use as the l		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribut	e to the cause of death?
Division of Vital Records, P.O. rel or Attending Physician: The law requires that the rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	g p		1 Ye	s 2 🗸 No 3	Probably 4 Unknown
requi	ompleted		24a. Was autor		re autopsy findings available r to completion of cause of
of Vital Records ing Physician: The law requi After this certificate has been uneral director, page 2 should	E I		perfo	ormed? dea 2 No 1	th? Yes 2 No
ant T		25. Was case referred to medical 26.Place of Death (Chec	k only one)		
Vita	P P	1 V Yes 2 No	sing Home 5		Other:
n of ling P		27. Manner of Death  28a. Date of Injury (Month, Day, Year)  1 Natural 5 Pending  The 3 // / 2008  1 Yes 2 No	,	how injury occurred	
SiOt Attenc death ector:	lati.	Accident Pending Investigation   Fnd 3/4/2008 Fnd 10:15 am   1 Yes 2 X No   28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f Location (	Street and Number of	or Rural Route Number, City
Divis	Certification:	Suicide b X Could not be determined (Spacific)	3028 Hea	State) thcoat Ct. V	Waldorf, MD
lospit 4 hour uner?		4 Homicide 199a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and check only			
Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page 2	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d at the time, date	and place, and due	to the cause(s)
F % F 8	₹	29b. Signature and title of certifier 29c. License number		29d. Date signed	(Month, Day, Year)
		Mene Grasself, MD O.C.M.E.		March 5, 200	8
	İ	30. Name and address of person who completed cause of death (Item 23a)	21201		
		Mélissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, Mi	L Z 1ZU 1		
Sta Regist	ate rar	31. Date filed (Month, Day Year) 2008 32. Registrar's Signature			

OCME

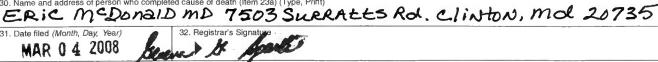
		/Medi Exami	
3		uneral irector	
2-0036	72 hours after death with the Maryland	natural", or Items 23a or 28a-f show lical Examiner must be notified at	eted by Funeral Director

			Registrar				00,	inicate		Douin			Reg. No	0.0	_0_	001	
	Physic	an	1. Decedent's Nam	e (First, Middle, La	st)							Date of D     Month	eath Da	Z U U	ear	3. Time of	Death /
7.4	/Medi		MICHA	EL J. NI	ELSON									2008		6:24	РМ
1	Examiner 4a. Facility Name (If not institution, give street and number)							4b. City, Town, or Location of Death						4c. County of Death			
HOLY CROSS HOSPITAL								SILVER SPRING					MONTGOMERY				
1.0	Funeral		5. Social Security N			je (In yrs. las		If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of B	irth av. Year	9.	Birthp	lace (State o	r Foreign
ш	Director		252-21-	-2519	IXM 2□F	18	Yrs.	WOTHERS	Days	110013	IVIII I.	7/20/				RGIA	
	ъ.		Usual Residence of			1.0 00	- :										
	how	_	10a. State	10b. County			Town or Lo		шо.	. 7					יו	0d. Inside Cit	
	e Ma-f s	cto	MD	PG		E.T.	• WA	SHING	TOI	N						1X□ Yes	2   140
	ith the Marylar or 28a-f show be notified at	Director	10e. Street and Nu	mber				10f. Zip C	ode				10g. C	itizen of Wha	t Cour	ntry?	
	23a (	a	708 CF	ARNOUSTI	E LANE			2	074	44			U	.S.A.			
	dea	Funeral	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13.1	Was Decede	nt of H	lispanic Or	rigin? (Spe	ecify Yes or N Rican, etc.)	0-	14. Race - / Black, \			
9	after or Ita	亞	1 Never Marr	ried 2 ☐ Married	1 ☐ Yes 2 ☐ If Yes, Give	<b>N</b> o		1 ☐ Yes 2				Thousand occup					
215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ont, the Medical Examiner must be notified at	by	3 ☐ Widowed	4 ☐ <b>P</b> ivorced	Year or Dates:			103 21	ANO	Specify				Specify:	B	LACK	
5-0	72 h natu dical	Completed	(Spec	15. Decedent's Ed	ducation ade completed)	1	(Give	dent's Usual kind of work	done	durina mo:	st of worki	ina	16b. l	Kind of Busin	ess/Ind	dustry	
21	within iene. than "	혈	Elementary/Seco		College (1-4or	5+)	life.	DO NOT use	retired	d)	-, -, -, -, -, -, -, -, -, -, -, -, -, -	9					
21	filed wi Hygien ther th	5			2		SIT	E MAN	AGI	ΞR				CONS	TRU	JCTIO	N
bu	al Hy	ge (		(First, Middle, Last						18. Moth	er's Name	(First, Middle	e, Maide	n Surname)			
<u> a</u>	uld b Ment rrkec	To Be	PLEZY	L. NEI	SON					WI	LLIE	B. A	LFO:	RD			
Maryland	2 should be fi and Mental H Is marked ot raumatic ever	ľ		ame/Relationship (								al Route Num				,	
	s 1 and 2 should be filed within 72 hours after death with the Maryls of Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f shouther traumatic event, the Medical Examiner must be notified at		REBECCA	4 COLLIE	ER/FIANCE	EE	708	CARN	OUS	STIE	LN.	FT.W	ASH:	INGTO	ON,MD 20744		
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tr once.		20a. Method of Dis			000	ce of Dispo	sition (Name	of er plac	ce)		Date	20c. L	ocation - Cit	y or To	own, State	
Ĕ	Pages nent of H int: If ite			□ Cremation 3 X 5 □ Other (Specif	Removal from State (fy)	I .	-	MEM.	•		3/3	/08	AM:	ERICU	S ,	GA	
alt:	permit. Pag Department Important: I any Injury o		21. Signature of Fu	uneral Service Lice	nsee							ICKLA					ICES
ű	Depa Impo any Ir		1 de leu	Mad 18	Stowart							D. CA					
у.			23a. Part1. Enter t	ne disease, dr.com	plications that cause	d the death.	Do not ent	er the mode	of dyir	ng, such as	s cardiac o	or respiratory	arrest,			Approximate Interval Bet	э
	Di di		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximately a such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Onset and E	veen Jeath			
	Physician /Medical		disease or condition resulting in death)  a. CARD TOPULMONARY ARREST  Due to (or as a consequence of):										INSTAI	TL			
	Examiner				Due to (or as	a conseque	nce of):										
6		ìī.	Sequentially list co	inditions,	b. Due to (or as	a conseque	nce of):								-		
	ted sit	Ē	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	anying injury	240 10 (0. 40	a sollad quo									- 1		
	and and	Examiner	that initiated events resulting in death)	5	c. Due to (or as	a conseque	nce of):								-		
9	be e ician buria				•		,										
68760,	cate phys	g			►d												
ox 6	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	an/Medical	IF FEMALE:		23c If was outcome	of pregnance	OV.										
Bo	attend for us	ian	23b. Was decedent pregnant in the past 12 months?					3 ☐ Ectopic pregnancy					23d. Date of delivery  Month Day Year			/ear	
	the a	/sic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other						Other (specify)								
P.0	res that the de signed by the s be detached t	Physicia	Part II. Other significant conditions contributing to death but not resulting in the									23e Did	ie. Did tobacco use contribute to the cause of de			eath?	
S,	res the	by															
oro	w require been sign	ted	STRO		837								1163 2		J F TOL	ably 4£30	7 IKI OWI I
ec	has by	윤	TRAC	CHEOSTON	Ч Х ———————							24a. Wa	DDSV	24b. Wer	e auto	psy findings a mpletion of ca	available ause of
or Vital Records,		Completed	GAS!	TROSTOM	Y TUBE							per 1□ Yes	formed? 2 □XN	o dea	th?	2 🗆 No	
Ħ	ician: Th certificate rector, pag	Be C	25. Was case refer	rred to medical						26. Plac	e of Death	n (Check only					
>	nysic lis ce direc	10	examiner? 1 ☐ Yes 2 ☐	ζNo	Hospital: 1 🗀 Inpatio	ent 2. □ <b>X</b> EF	R/Outpatier	nt 3□ DOA	Oth	er: 4□N	ursing Ho	me 5□Res	sidence	6 □Other (	Specif	y)	
0	ding Phys		27. Manner of Deal		28a. Date of Inju (Month, Da		8b. Time of Injury	f 28	c. Injur Wor	ry at		28d. Describe	how inju	ury occurred			
<u>5</u>	ath. r: Af	atio	1 □Natural 2 □ Accident	5 ☐ Pending investigation	n	, , , , ,	,,	М		Yes 2	No No						
Division	Attend r death. ector: / by the f	Ę	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	Zoe. Place of In	ury - At hom tc. (Specify)	e, farm, str	eet, factory,	office			28f. Location City or To	(Street a	and Number o	r Rura	al Route Num	ber,
	al or	Certification:			ballating, co	ic. (Opcony)						Oily of Te	JWII, Ola	16)			
	bourd hourd neers y fille		29a. Certifier	XXCertifyIng Pl	nysician: To the best	of my knowl	edge, deat	h occurred a	t the ti	me, date a	nd place,	and due to the	e cause(	s) and manne	er as s	tated.	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical	(Check only one)	2 Medical Exam	miner: On the basis of and manner st	ated.	ni and/or in	vesugation,	ııı my o	pinion, de	atri occur	red at the time	e, date al	nd place, and	aue t	o tne cause(s	)
	To the To the Comp	Z	29b. Signature and	I title of certifier						e number			29d. D	ate signed (A	Nonth,	Day, Year)	
			Ba	1/2-					286	556			]	FEB.	26	, 2008	8
	Se		30. Name and add	ress of person who	completed cause of c	death (Item 2	3a) (Type,	Print)									
	000		RAVI	PASSI,	MD 15225	SHA	DYGRO	OVE R	D,	#20	8 RO	CKVIL	LE,	MD 2	085	50	
	Sta	ite	31. Date filed (Mor.	oth, Day, Year)		rar's Signatu											
			MAR 0 4	711118	No.												

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Day **Physician** SAMUEL OJOMO 4:14 A<sup>M</sup> 2008 02 18 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** SOUTHERN MARYLAND HOSPITAL PRINCE GEORGES CLINTON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days NONE 1 X M 2 □ F Director 68 09/23/1939 NIGERIA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b, County show "natural", or items 23a or 28a-f shovidical Examiner must be notified at 1X Yes 2 □ No WALDORF Funeral Director CHARLES 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20603 NIGERIA 10686 SOURWOOD AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: BLACK Completed by 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 4 YEARS <u>SALESMAN</u> permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ABIFA ANIMATU OLANEYE OJOMO 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10686 SOURWOOD AVE. WALDORF, MD 20603 ADEYEMI OJOMO/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 3/21/2008 LAGOS, NIGERIA OJOMO FAMILY PLOT 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 21. Signature of Fupural Service Linensee 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MASSINE **Physician** /Medical Due to (or as a consequence of): nenisu Enurphalitis **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician the use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be o Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2☒ No 24a. Was an , page 2: autopsy performed certificate 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 | Inpatient 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier D0064055 2-18-08

State Registrar 31. Date filed (Month, Day, Year)

MAR 0 4 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - State Registrar	of Maryland / Dep	artment of Health		giene	08469
4	Physici /Medic	al		rtiz			1, 2008 Year	3. Time of Death 2:00 a <sup>M</sup>
I	Examin	er	4a. Facility Name (If not institution, give street and Washington Adventist 5. Social Security Number 6. Sex	Hospital 7. Age (In yrs. last birthday	4b. City, Town, or Location  Takoma Park  If Under 1 Year If Under	24 Hrs. 8. Date of Birt		ath  cgomery  rthplace (State or Foreign ountry)
l.	Director		217-72-2612	77 Yrs.	Months Days Hours	Min. (Month, Da) Dec. 28	, 1930 Gi	10d. Inside City Limits
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiens iftem 27 is marked that Hygiens in a received the state of the marked other treums 23a or 28e-f show other treumstic event. If a Madical Evant ear must be notified at	Director	Maryland Montgo  10e. Street and Number  327 University Blv	mery Sil	ver Spring  10f. Zip Code  20901		10g. Citizen of What C	1 ☐ Yes 2 🖾 No
2-0036	urs after death al', or Itams 23	by Funeral I	11. Marital Status  1 □ Never Married  2 ★ Married  1 □ Yes.	ecedent Ever in U.S. 13. Forces?	Was Decedent of Hispanic Or If Yes, specify Cuban, Mexical ★★Yes 2□ No Specify:		- 14. Race - Am Black, Whi	
0-01717	d within 72 ho giene. or than "natur. I're Medical.	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) Colleg 12	e (1-4or 5+) (Given life.	edent's Usual Occupation e kind of work done during mos DO NOT use retired) cary Technicia		16b. Kind of Business State Gove	,
ryland	2 should be filed to and Mental Hygie is marked other freumatic event, It	To Be C	17. Father's Name (First, Middle, Last)  Domingo Gonzalez Caste  19a. Informant's Name/Relationship (Type, Print)		18. Moth	er's Name (First, Middle, Felisa Esco	obar	Zin Coda)
аптоге, ма	t. Page rtment o rtent: If rjury or		Gabriel Ortiz/Husband  20a. Method of Disposition  ★录Burial 2 □ Cremation 3 □ Removal fro  '4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	20b. Place of Disp cemetery, cre Villa de	7 University Bi osition (Name of omatory or other place) Guadalupe	Date March 7, 2008	Silver Spr 20c. Location - City of Guatemala	ring, MD 20901 rTown, State City, Guatemal
	Pnysician /Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	at caused the death. Do not en	2. Name and Address of Facility of Trancis J. Col. 1000 University other the mode of dying, such as	Blvd, W., S	Silver Spri	Approximate Interval Between Onset and Death
.O. DOX 00/00	death certificate be e attending physicie od for use as the bur	Physician/Medical E	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	olivery Day Year
necords, r	w requires been sign should be	Completed by Pi	Part II. Other significant conditions contributing to	o death but not resulting in the u	underlying cause given in Part I	1 🗆 Y	an 24b Were a prior to med? death?	robably 4 Unknown untopsy findings available completion of cause of
on or vital	ling Physicien:  After this certifice funeral director, p	To Be	27. Mann of Death 1 Natural 5 Pending (N	☑Inpatient 2 ☐ ER/Outpatie te of Injury tonth, Day Year)  28b. Time of Injury	nt 3□ DOA Other: 4□ Nu	a of Death (Check only oursing Home 5  Residence Page 1984). Rescribe h	ne)	
DIVISION	ospitel or Attendi hours after death. unerel Diractor: A y filled in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place but th	28f. Location (S	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospitel or Attend within 24 hours after death To the Funerel Diractor: completely filled in by the	Medical (	(Check only 2 Medical Examiner: On the	the best of my knowledge, dea e basis of examination and/or in anner stated.	th occurred at the time, date an westigation, in my opinion, dea	th occurred at the time,	cause(s) and manner a date and place, and du 29d. Date signed (Mon	e to the cause(s)
1			· Negus	ause of death (Item-23a) (Type	DYJ	471 5	03/01 Iver SP	1208 ring, MD
•••	Sta Registr		31. Date filed (Month Day, Year) MAR 0-3 2008	SSI CV	m. D. Ini	String	St. Su.	ite#214

To Be

	Plea	ise Type or	Print in B	Black In	delible Ink.	Ensure A	II Copies	s Are	e Legi	ble.	
For		State of	of Marylan	d / Depa	artment of H	lealth and N	Mental Hy	/gien	е		
1 - State Registrar				Ce	rtificate of	Death		Reg. N	lo.)	28	0817
1. Decedent's Nam	e (First, Middi	e, Last)				<del></del>	2. Date of Do		ay	Year	3. Time of Death
GERTR	UDE E	. OLIVER							2008	rear	15:10 p <sup>M</sup>
4a. Facility Name (i	lf not institutio	n, give street and nu	ımber)		4b. City, Town, o	r Location of Death			c. County	of Death	
Tawes 1	Nursing	g Home			Crisfie	ld			Some	rset	
5. Social Security N	lumber	6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth av. Yea	r)	9. Birthp	place (State or Foreign
577-68-8	019	1 □ M 2 🛣 F	9	5 Yrs.	Month Days	Trodis IIIII	July 2				ngtan, D.C.
Usual Residence o			I to to								
10a. State	10b. County		10c. City	, Town or Lo	ocation					1	10d. Inside City Limits
MD	Worces	ster	Poco	moke (	City						1X Yes 2 No
10e. Street and Nu					10f. Zip Code			10g. C	itizen of \	What Cour	ntry?
2305 Wood	dland (	Court			21851				U	ISA	
11. Marital Status		12. Was Dec Armed F	edent Ever in U.	S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)     14. Race - American Indian, Black, White, etc.						
1 Never Marr	ried 2□ Mar	ried 1 ☐ Yes	2 No		4 TV 0 TV 0 V				etc.		
3 🛚 Widowed	4 ☐ Divorced	If Yes, G Year or D	oates:		1 ☐ Yes 2 ☑ No Specify: White				vhite		
(Spe	15. Deceder	nt's Education est grade completed)		(Give	ecedent's Usual Occupation 16b. Kind of Business/Industry					dustry	
Elementary/Seco		<del></del>	(1-4or 5+)	`life.	life. DO NOT use retired)						
12				Homen	emaker Domestic						
17. Father's Name	(First, Middle,	Last)			18. Mother's Name (First, Middle, Maiden Surname)						
John Zom	neck					Catherin	ne Metz	ger			
19a. Informant's N	ame/Relations	ship (Type. Print)		19b. Maili	ng Address (Street	and Number or Ru	ral Route Numi	ber, City	or Town,	State, Zip	Code)
Ronald J	. Olive	er (son)		2305	05 Woodland Ct., Pocomoke City, MD 21851					51	
20a. Method of Dis			20b. P	lace of Dispo	osition (Name of matory or other place	ce)	Date	20c.	Location -	- City or To	own, State
1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury (				1	2008	Sa	lich	ury,	MD		
21. Signature of Fig.			, and								
Much	DAF	2000		1	Name and Addre Holloway 103 Linde	runeral H	dome, Pi Pocomoka	cotes - Ci	siona tv	LASSO MD21	ciation 1851
23a. Part1. Enter t	the disease, o	r complications that	caused the death								Approximate
23a. Part1. Enter the "isease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final				ASCVI						Interval Between Onset and Death	
disease or condition resulting in death)	òn	a	(		112001	, ,					
		Due to	(or as a consequ	uerice ot):							

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine

IF FEMALE:

	ASCVD	•
Due to (or as a consequence of):		
Due to (or as a consequence of):		
Due to (or as a consequence of):		

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Physician/Medical Medical Certification: To Be Completed by

3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c

If yes, outcome pt pregnancy	
1 ☐ Live birth 2 ☐ Fetal death	3 ☐Ectopic pregnar
4☐Pregnant at time of death	5 Other (specify)
Q I Inknown	

3 ⊟Ectopic pregnancy 5 ⊟ Other (specify)	

	23d. Date of delivery				
	Month	Day	Year		
23e. Did tobacc	o use contribute t	o the cause	of death?		

Part II. Other significant	conditions contributing	to death but not resulti	ng in the underlying ca	use given in Part I

	1 □ Yes 2)	No 3□Pro	bably 4 □Unknown
	24a. Was an autopsy performed? 1□ Yes 2√2 No	24b. Were aut prior to co death? 1 ∐ Yes	opsy findings available ompletion of cause of 2 No
26. Place of Death (0	Check only one)		

25. Was case examiner 1 ☐ Yes	e referred to medical
27. Manner o	f Death

1 Inpatient	2	ER/Outpatient	3 🗆 🛭	OOA	Other:	Nursing H	ome	5 🗆 Residence	6 ☐Other (Specify)
Date of Injury (Month, Day Yea	ar)	28b. Time of Injury			Injury at Work?			Describe how inju	
	- 1		M		1 🗌 Yes	2 □ No			

7. Manner of Death	
1 Natural	5 Pending
2 Accident	investigation
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury at Work?	,	28d				
		M	1 ☐ Yes	2□No					
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)									

∐No	
	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only
one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature	and title of certifier	
	N	(

31. Date filed (Month, Day, Year)

290. Licei	ise number
D	48098

29d. Date signed (Month, Day, Year) 03/03/ 2008

BA 1

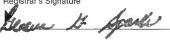
To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. - 201 Hall Hwy., Crisfield, MD 21817
32. Registrar's Signature Vijay Karumbunathan,

State Registrar

2008



#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SANCHEZ PANAMEN D Day Month Vear **Physician** 2:16 p M February 25 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 **x** M 2 □ F **Director** 578-06-2245 57 December 8,1950 El Salvador Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 TNO Director Maryland Prince George's Hyattsville 10e Street and Number 10f Zip Code 10g. Citizen of What Country? El Salvador 1612 Dayton Road 20783 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1⊠Yes 2□No Specify: El Salvador Specify: El Salvadorian þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Tailor Clothing Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Manuel Panameno Maria Elena Sanchez ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) Olga D. Sanchez - Spouse 1612 Dayton Road, Hysttsville, Maryland 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cemetery 03/01/2008 Silver Spring, Maryland 21. Signature of Funeral Service Licenside 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANAPLASTIC LYMPHOMA **Physician** /Medical Due to (or as a consequence of): **Examiner** SEPSIS Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner RENAI ACUTE burial-trar Due to (or as a consequence of): PANCYTOPENIA Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ Ho Month Vear Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SYNOMOME 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed CLOSTRIDIUM DIFFICILE 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ Dec 24a. Was an page 2 autopsy performed? 1□ Yes 2 A No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: n 24 hours after death.

The Funeral Director; A pletely filled in by the funeral bletely filled in by the funeral filled within 2

To the I

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier DAMIN HD

29c. License number D-59284

🕊 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHAHID SHAMIM, HD, WASTONATON ADVENTIST HOSP, TALLOWA PARK
MD-20912

State Registrar

Medical

31. Date filed (Month, Day, Year) 0 3 2008 MAR

4 Homicide

(Check only

29a. Certifier



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Elizabeth February Dorothy Proctor 27,2008 10:23p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1605 Mint Court Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Days 1 □ M 2 X F 220-32-6969 85 Director 7/25/1922 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at 1X Yes 2 □ No Directo Prince Frederick Maryland Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1605 Mint Court 20678 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Hotel Clerk **Hospitality** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ John Alexander Proctor Elizabeth Virginia Proctor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20678 19a. Informant's Name/Relationship (Type. Print) Linda Holland/ Daughter 1620 Mint Ct. Prince Frederick, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection 3/7/08 Clinton, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Adams Funeral Home PA 191 20605 Aquasco Rd. Aquasco, Maryland 20608 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final - Ian Physician 91 ncer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Lines underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed as the burial-transi Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No. 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by No 3 Probably 4 ☐Unknown 1 ☐ Yes Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performed page this certificate Division or Vital 2**5**€No Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient 2 5 Residence 6 □Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of eath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: or Attending 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and tj 29d. Date signed (Month, Day, Year) le of c completed cause of death/(Item/23a) (Type, Print) 30. Name and address of perso 2067 Year) 32. Redistrar's Signature 31. Date filed (Month, Day State Registrar 0 2008

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Physicia		Registrar 1. Decedent's Nam	ne (First, Middle, L	.ast)						Date of Death	1		3. Time of Death
dical Exami				Peeling						Month February 2			1204 hrs
Dr.		4a. Facility Name (	if not institution,		nber)		•	n, or Location o			4c. County		4.
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Funeral		5. Social Security I			7. Age (In yrs. la		If Under 1	Year If Under Days Hours			h(MM/DD/YYY)	Foreign	
Director		220-78-3	002 1	X M 2 F	4	8 Yrs	3.			Jan 11	1960_	Cour	MD MD
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or 28	Director							21126	-			703	
vith the s 23a e noti		11. Marital Status	urch Roa	12. Was Dece	edent Ever in U			21136 of Hispanic Ori	gin? (Spec		14. Race		an Indian, Black,
eath v item	Funeral	1 XNever Marr	ied 2 Marr	ied Armed Fo	rces?	lf Y		uban, Mexican		can, etc.)	Whit	te, etc.	
after d	by F	3 Widowed	4 Divor	oed If Yes, Give Year		1		No specify:			Specify:		
ours a	pe pe			y only highest grad		16a. Deceder	nt's Usual Occ nost of working	cupation (Give	kind of wor use retired	rk done d)	16b. Kind of B	usiness/In	dustry
36 n 72 l nan ", ii. al E	plet	Elementary/Sec	• • •	College (1-	-4 or 5+)	Fo	orklift	. Opera	tor		Lambe	er Co	mpany
5-0036 led within? Hygiene. I other than	Completed	17. Father's Name	12 (First, Middle, L	ast)						First, Middle, N	Maiden Surnam		
21215-0036  Juld be filed within 72 hours after death with the Maryland Mental Hygiene. In arked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at once.	Be C		•	l Peelin	ď			Vir	ainia	Phill	ins		
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mould Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	일	19a. Informant's N	lame/Relationship	(Type, Print)	_	19b. Mailin	ng Address (				ips nber, City or To		Zip Code)
MD and 2 shoulth and m 27 is aumati				ng/mother			air Av			inster Date	MD 2.	1157	Town State
		20a. Method of Dis		3 Removal fro	I	Place of Dispo crematory or o		or cernetery,		/2008	200. 2000		, , , , , , , , , , , , , , , , , , , ,
Page ment of		4 Donation 5	Other Spe	cify:		rroll C					Hamps		
Baltimore, permit. Pages I at Department of He Important: If ite injury or other ti		21 Signature of F	uneral Service Li	censee							Chapel, tminste		
Physician		23 Fart I. Enter t	the disease, or	omplic flons that ca	aused the death	n. Do not enter	the mode of d	ying, such as	cardiac or r	respiratory arr	est, shock, or h	eart	Approximate Interval
√ /Medical		failure. List or	nly one cause of	each line. a. Smoke Inha									Between Onset and Death
xaminer		Immediate Cause or condition result		Due to (or as a		of):							
	L	Sequentially list o	onditions,	b		-n.							
	ine	if any, leading to i cause. Enter Und	derlying Cause	Due to (or as a	consequence o	DI).							
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ox 68760, eath certificate be executed a strending physician and for use as the burial - transit	<u>a</u>	UNPENDE	<u> </u>	d. X AMENDED	Itoms	/h/28f	ner MF	0.02/20	6/200	8 Carro	o11 Co.	wi1	
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Box 687; death certific the attending ped for use as the	Sici	1 Yes 2			ant at time of d	eath 5 C	Other (Specify	)			6		
the de	Physician/			ns contributing to		resulting in the	underlying ca	use given in F	Part I.	23e. Did to	obacco use con	tribute to	the cause of death?
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on tendin eath. or: A	<u>ئ</u> ِ	1 Natural 2 Accident	5 Pendi	rg gation Feb 20,	Day,Year)	FOUND: 1203 hrs_		1 Yes 2 ₩	No				
Division spital or Attendi hours after death. meral Director: /	Certification:	3 Suicide	6 Could	not be 28e. Plac	e of Injury - At I	home, farm, str	eet, factory, o	ffice building,	etc.	28f. Location ( or Town,	Street and Num State) <b>Reis</b>	nber or Ru sters	ral Route Number, City
Di Hospital 24 hours a Funeral I	l e	4 Homicide		(0,000)/	Single Fa								
H 4 4 9		29a. Certifier (Check only one)	Certifying Phy Medical Exam	vsician: To the bes	st of my knowle of examination	dge, death occ and/or investig	urred at the til ation, in my o	me, date and p pinion, death c	place, and o occurred at	the time, date	se(s) and mann and place, and	ier as state d due to th	eu. e cause(s)
To the within To the complet	Medical	29b. Signature an		and manner s	tated.			icense numbe					nth, Day, Year)
WIL	-	1/1/1	1. 1.1	2				D.C.M.E.			February	21, 200	08
10		30 Name and add	dress of person	who completed caus	se of death (Ite	m 23a)					L		
		Laron Lock		sistant Medica			n Street, E	Baltimpre, I	MD 2120	01			
	tate	31. Date filed (Mo		40.	egistrar's Signa	ture	and a						
Pagis			FR 2 6	2002 1 /2	Frail	H. A.	DATE A						

DHMH 17 Rev 1/2001

ORIGINAL

# Amended Items 29d & 30 per Physician 02/26/2008 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland / Dep Registrar Ce	artment of Health and N rtificate of Death	, ,	ene g. No. O. O. O.		
		4,	Decedent's Name (First, Middle, Last)		2. Date of Death	2000	3. Time of Death	
	Physicia		Inez E. Parsons		Februar	y 24, 2008	3:07 p <sup>M</sup>	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea		
J.			Dove House Hospice	Westminster		Carroll		
	Funeral Director		5. Social Security Number 6. Sex $1 \square$ M $2 \square$ F 7. Age (In yrs. last birthday, Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) C	thplace (State or Foreign ountry) arvland	
	spiller our - dete		Usual Residence of Decedent		1.00 57	-725	<u> </u>	
	ylan		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits	
	e Ma la-f s tified	cto	Maryland Carroll Wes	stminster			1 ☐ Yes 2 X No	
	ith th or 28 e no	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What C	ountry?	
	ath w		3072 Littlestown Pike	21158		USA		
20	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 反 No If Yes. Give	Was Decedent of Hispanic Origin? (Si if Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 ★★ Specify:	oecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi	te, etc.	
ğ	hours tural'	d b	3 ☑ Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education 16a. Dece	edent's Usual Occupation	1	6b. Kind of Business	White	
Maryland 21215-0036	n 72 "nat	Completed	(Specify only highest grade completed) (Give	e kind of work done during most of wor. DO NOT use retired)	king	Ob. Kind of Dusiness	Andustry	
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au		To Be	Ernest Ridgell	Florer	ce Cecel:	ia Ridgell	L	
$\leq$	shoul nd M mari	F		ing Address (Street and Number or Ru				
	₽ <b>£</b> 7; <b>‡</b>		Joseph Parsons son 3072	Littlestown Pike	Westmins	ster, MD	21158	
<u>6</u>	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		20a Method of Disposition 20b. Place of Disp	osition (Name of ematory or other place)	Date 2	20c. Location - City or	Town, State	
5	Pages nent of nt; If its iry or o		1 Burial 2 Cremation 3 Removal from State	canch Cem. 2/27	7/08 W	estminste	- MD	
Baltimore,	permit. Pages 1 an Department of Heal Important; If item 2 any injury or other once.		21 Stanature of Funeral Service Licensee	2. Name and Address of Facility Pri L2 Washington Rd.	tts Fune	ral Home 8		
			23a. Party. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between	
,	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. AcuTe On (	Chronic Res	piraturi	1 failu	Onset and Death	
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	cate be executed oblysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events					
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). Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	elivery Day Year	
P. 0	res that the de signed by the a be detached t	Ph	Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I	23e Did tob	acco use contribute	to the cause of death?	
Records,	w requires the speed spe	by	Part II. Other significant conditions continuously to death out not resulting in the	andenying cause given in Fact.	1 ☐ Yes	tobacco use contribute to the cause of death?  Yes 2 □ No 3 □ Probably 4 □ Onknown		
Kecc		Completed			24a. Was an autopsy perform	v 🚽 prior to	autopsy findings available completion of cause of	
Vital	lan: ortifica stor, I	Be C	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one	9)		
>	Attending Physician: r death. ector: After this certifics by the funeral director, p	ToE	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	nt 3□ DOA Other: 4□ Nursing H	lome 5 🗆 Resider	nce 6 Other (Sp.	ecify) HOSPICE.	
0	neral	ü	27. Manney f Death 1 V atural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at Work?	28d. Describe how	w injury occurred	,	
<u></u>	ath. or: Af	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No				
DIVISION OF	r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, so building, etc. (Specify)	treet, factory, office	28f. Location (Str. City or Town,	reet and Number or F , State)	Rural Route Number,	
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, dea  2. Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occu	e, and due to the ca urred at the time, da	ause(s) and manner a ate and place, and di	as stated. ue to the cause(s)	
	To th Withir To th Somp	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Mor	nth, 62/25/2008	
	WJL		And Aldern	139502 0	10	H257	05	
	34		30. Name and address of person who completed cause of death (Item 23a) (Type	0 = -			21157	
	3		Spea S. Hosain and 4	47. Each Main	stree t	wes tuy	21157 MJ	
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	4			210/3	
	Registr	ar	FEB 2 6 2008 Ellague #	March o				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12:15 AM January 29, 2008 Mildred Gertrude Purnell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Atlantic General Hospital Berlin If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Yrs. Director 220-26-2259 81 1926 Maryland April 05, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itama 23a or 28a-f ahor the Medical Exeminer must be notified at 1 ☐ Yes 2 ☐ No Directo Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21811 8833 Bald Eagle Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married ○ i /29 / 2008 Maryland 21215-0036 δ 1 ☐ Yes 2 ☑ No Specify: Black 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer - Self-employed Poultry Poultry 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental George W. Collins Ethel G. McGregory 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 Department of Health a Important: If Itam 27 is any injury or other trai once. Bobby Purnell/Son 501 Plover Road - Salisbury, Maryland 21801 imore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Paul UMC Cemetery 2/5/2008 Berlin, Maryland 21, Sign ture of Funeral Service Licensee 22. Name and Address of Facility 1213 Jersey Road 21801 Jolley Memorial Chapel, P.A. - Salisbury, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician regurgitation severe Mitral /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ed by the ettending physicien and detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 220~2 ል metabolic encephalopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No Vital within 24 hours effer deeth. To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check only one Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or Medicai 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) · van Egmond Mo D0056307 January 29, 2008 30. Name and address of per on o completed cause of death (Item 23a) (Type, Print) J. van Egmond MD, Atlantic General Hospital, 9733 Healthway Drive, Berlin, MD 218/1 31. Date filed (Mohub, Day, Year)
JAN 3 1 32. Pogistrar's Signature State 2008 Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month **Physician** Howard Lee Redmond, 10:14 a<sup>M</sup> 29. 2008 February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☑ M 2 ☐ F Director 95 577-24-4399 June 19, 1912 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2√ENo Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2706 Lindell Street 20902 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 Married 1 To Yes 2 □ No If Yes, Give Year or Dates: To Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White ≥ 3 Widowed 4 Divorced WWII Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than 10 Heating & Air Conditioning HVAC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be finance in the second se Be is marked William Howard Redmond Minnie Elizabeth Herbert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is Norma Z. Redmond/Wife <u> 2706 Lindell Street, Silver Spring, MD 20902</u> or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 2. 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State injury o Metropolitan Crematory 4 Donation 5 Dother (Specify) 2008 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd. W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart hallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Urinary Tract Infection 2 Days /Medical Due to (or as a consequence of): Examiner 1 Day Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Benign Prostatic Hypertrophy, Congestive Heart Failure, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Arteriosclerotic Cardiovascular Disease, Anemia, Sepsis has autopsy performed? page certificate 1 Yes 2 No Diabetes Mellitus 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) Hospital or Attending 1 X Natural 5 ☐ Pending investigation 1 Yes 2 No death 2 Accident 24 hours after death Funeral Director: filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P 2 Imanon D53367 February 29, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shyamsundar Rajan, MD 9801 Georgia Avenue, Silver Spring, MD 20902 Registrar's Signature 31. Date filed (Month, Day, Year) State 03 2008 Registrar

State of Maryland / Department of Health and Mental Hygierie [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year James Robert Savage Sr. 03 03 2008 3:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Garrett County Memorial Hospital Oakland Garrett 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/27/1928 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□F Director 79 Maryland 212-26-8548 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show the Medical Exar in an must be notified at 1 ☐ Yes 2X No Director Garrett 0akland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 'naturel', or Items 23e 498 Mansfield Road 21550 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify: 3 Widowed 4 Divorced WWII White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) Construction Truck Driver and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Fannie Lovella Morgan John Albert Savage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a :: If item 27 Is 498 Mansfield Road, Oakland, Maryland 21550 Mary K. Savage/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. 03/08/2008 Morgantown, WV \* 4 ☐ Donation 5 ☐ Other (Specify) Omega Creamatory 21. Signature of Funeral Service Licencee 22. Name and Address of Facility Stewart Funeral Home 32 South Second Street, Oakland, Maryland 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ses toli week on /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed pertense Due to (or as a consequence of): attending physician a for use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4☐Pregnant at time of death 5 Other (specify) ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 2 □ No 3 □ Probably 4 □Unknown 1 Yes 24a. Was an autopsy performed? 1 ☐ Yes 2 € 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No funeral director, page 2 : 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only of examiner? Other: 2×No Certification: To 1 🗌 Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of ate of Injury (Month, Day Year) eath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation М within 24 hours after deat To the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) cahland, ud 21550 13079 margaret garrett his 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2008

			1 - For State Registrar	State of Ma	aryland /	•			ealth a	and M		giene Reg. No.	008	08478
П	Physici	ian	1. Decedent's Name (First, Middle, Las	0)							2. Date of Dea	Day	Year	3. Time of Death
	/Medi		MARY ELLEN	SANDERS							2/23	/200	8	2155 M
4	Examir	ner	4a. Facility Name (If not institution, give Garrett Count			sn.	· ·	Town, or clan	Location o	of Death		1	ounty of Dea .rrett	
	Francis		5. Social Security Number 6. Se		e (In yrs. last		If Under		If Under:	24 Hrs.	8. Date of Birt			thplace (State or Foreign
Н	Funeral Director			□м 2 <b>∏</b> F	58	Yrs.	Months	Days	Hours	Min.	(Month, Da)	y, Year)	C	ountry) WV
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	with t	ā	10e. Street and Number  RR 2 Box 147				10f. Zip	Code 5764				_	on of What C	ountry?
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(0	itied within 72 hours after death with the Maryland Hygiene. Ither then "netural", or Items 23a or 28e-f show ont, Its Medical Examiner must be maiffied at	Funeral	1 ☐ Never Married 2 Married	Armed Forces? 1 □ Yes 2 1 X						, Puerto I	cify Yes or No- Rican, etc.)	''	Black, Whi	te, etc.
93	rali, o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	☐ Yes	2⊠ No	Specify:			S	pecify: V	Mhite
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2	d 2 should be h and Mental 7 is marked of treumetic eve	F	19a. Informant's Name/Relationship (7	ype, Print)	1 1	9b. Mailing	g Address	(Street a			l Route Numbe			Zip Code)
Ž			Wayne Sanders	/Spouse		RR 2	Вох	14	7, T	erra	a Alta	, WV	26	5764
J.C.	Se to L	1 3	20a. Method of Disposition	D	20b. Place ceme	of Dispos	ition (Nan	ne of ther place	e)	D	ate	20c. Loca	tion - City or	Town, State
Ë	nit. Pages artment of I ortent: If It injury or o		1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		Fai	th C	emet	ery	2	/27/	2008	Ter	ra Al	ta, WV
Baltimore,	permit. Page Départment : Importent: It any injury o		21. Signature of Funeral Service Licens	see lucitur		22. Ar 10	Name anthur	d Addres	wri	ght	Funer	al H	ome	WV 26764
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	p =	je l	Sequentially list conditions, if any, leading to humadiate cause. Enter Underlying Cause (Disease or injury	Dua to (or as	a cunsequene	o of).					0			
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Вох 6	death certificate be executed e attending physician and id for use as the burial-Iransit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								236	d. Date of de	livery
m.	death e atte	Iclai	in the past 12 months? 1 □ Yes 2 No	1□Live birth 4□Pregnant at			Ectopic pro Other (spe						Month	Day Year
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of Vital Records, P	Se UBO	ρλ	Part II. Other significant conditions co	intributing to death be	ut not resulting	g in the und	derlying ca	ause give	n in Part I.		23e. Did to	-		o the cause of death?
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ž	0 4 5	E									autop perfor 1 Tyes	med?	death?	completion of cause of
ita	ysicien: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only or			
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ion	Attending P r death. ector: After t by the funera	atlon;	27. Manner of Death  Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Injur (Month, Day	ry 28b y Ye <i>ar</i> )	. Time of Injury	M 28	Bc. Injury Work 1 🔲 Y	at ? (es 2 🗆 f		8d. Describe h	ow injury o	occurred	
Division	f or Atte after dea Directo I in by th	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	ury - At home, c. (Specify)	farm, stre	et, factory	, office		2	8f. Location (S City or Tow	treet and f n, State)	Number or R	ural Route Number,
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	Fo the within Fo the comple	Med	29b. Signature and title of certifier				29c.	License	number		2	29d. Date s	signed (Mont	th, Day, Year)
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		T	30. Name and address of person who c	ompleted cause of d	eath (Item 23a	a) (Type, P	rint)	00	1					
			Roger A. Lewis	-	603 5	Hat	e K	tve,	, Te	rra	AH	a v	W 20	6764
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Shawna Noel Sta		1- For State	St	ate of Maryla		oartmen e <i>rtificate</i>			id Men	tal Hy	/giene	Dec 1	. 2(	108	0847
Physicia	ın/	Registrar 1. Decedent's Nam								Т	2. Date of		10.		e of Death
Medical Examin	ner	Shawna No	oel Sta	Stallman					February 29, 2008 Year 1643 hrs						
J. Mr.		4a. Facility Name (i	if not institutio	n, give street and nu	ımber)			City, Town, or McHenry	r Location of	of Death			4c. County of Garrett	Death	
Funeral		5. Social Security N		6. Sex	7. Age (In yrs	s. last birthda		If Under 1 Yea	ar If Unde	er 24Hrs.	8. Date o	f Birth(N	/M/DD/YYYY)	9. Birthplace	(State or
Director		220-27-53	397	1 M 2XF		18		Months Day	/s Hours	Min.	7		1989	Foreian	Maryland
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land f shov	힏	MD	Garre	ett	Fr	riends									Yes 2 X No
Mary r 28a- ed at	Director	10e. Street and Nu						Of. Zip Code				10g. Citizen of What Country?			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be maified at once.		928 New	Grave.	l Hill Rd		in U.S. 13. Was Decedent of Hispanic Ori			~:-0 / C-	:fV		SA	A	lian Dioak	
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15- filed al Hyg ed oth	Be Co	17. Father's Name		•	18. Mother's Name (Fi							die, Mai	den Surname)		
2121: ould be fil Mental I. marked ic event,	To B	Wilbur St 19a. Informant's Na				19b. N	failing A	ddress (Stre				Numbe	r, City or Town	, State, Zip C	ode)
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Baltimore, permit. Pages 1 at Department of Hee Important: If ite	- 1	21. Signature of Fu	neral Service	Licensee	<b>.</b>								ral Hon		Α.
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x 68 h certi tendin	ਹ।	past 12 months		4 Pregr	nant at time of	death 5	=	death 3 r (Specify)	Letopi	ic pregna	шсу	, J	WOTH	Day	Tear
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Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the L	by P	Part II. Other signi	ficant condi	tions contributing t	o death but no	ot resulting in	the und	lerlying cause	given in Pa	art I.	23e. I		cco use contrib	_	use of death?
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tal Recian: The certificate ector, page	5											es 2	No 1	<b>✓</b> Yes	2 No
Division of Vital Records, tat or Attending Physician: The law requin rs after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	Be	25. Was case refer examiner?		Heenitel:	Inpatient 2	ER/Outpa	ationt 3	-	e of Death		only one)  g Home 5	. Do	sidence 6	Other: Scen	
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To th withi To th	Medical	2 🔻		miner:On the basis and manner:		- and/or mive	sligation				it the time,				
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	5	30. Name and addr Margarita K		who completed cau Assistant Me			11 Pen	nn Street, E	Baltimore	e, MD	21201				
Sta	ate	31. Date filed (Mon		677	egistrar's Sign	ature	a								
Pagist	2017	*A1	\D . 9	2008	Mr	10 A	and with	. D							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month Edgar Enrique Chirino Sanchez 22:13 M 3 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death University of Maryland Medical Center Bultimore If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Days 1 ☑ M 2 🗆 F 0872671966 Eluntalvador 41 none Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Va. Prince William Woodbridge 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5554 Neddleton Avenue 22193 El Salvador 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1XIYes 2□No Specify: Salvadoran Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Carpet Company Elementary/Secondary (0-12) College (1-4or 5+) Carpet Cleaning & Installation 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Luciano Chirino Ana Lilian Sanchez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) David Luciano Chirino (Brother) 14405 Coach Way Drive Centerville, Va. 20120 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State San Vicente El Sal 1 Burial 2 Cremation 3 Removal from State 03/06/2008 Family Cemetery 4 □ Donation 5 □ Other (Specify) Salvador 22. Name and Address of Facility
W. H. Bacon Funeral Home, Inc.
3447 14th Street, N.W. Washington, DC 20010 21. Signature of Funeral Service Licenses DACON, CC361 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) / Cervical Spine Injury Head Injury 2 hrs Due to (or as a consequence of): Vehicle Securitially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): INCATION HAPROVED BY Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? /es 2 No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 1 Ves 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury

Physician /Medical Examiner

Injury or other traumatic event,

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

hours after death with the Maryland

filed within 72

ould be f and Mental

Pages 1 and 2 should bent of Health and Men

permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra

Maryland 21215-0036

Baltimore,

and attending physician for use as the buria the director, this Director:

Examine Physician/Medical þ Completed Be Certification: To

The law requires that the death certificate be executed Hospital or Attending To the Funeral

Division or Vital Records, P.O. Box 68760

State Registrar

s of poson who completed cause of death (Item 23a) (Type, Print) ADAMSKURZ 5. Greene

6 ☐ Could not be

2 Medical

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. chaminer) On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner spated.

Motor Vehicle Crash

28f. Location (Street and Number or Rural Route Number, City or Town, State) I-686 Finzel Rd Frost wrg, MD

unknow

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

, MD

21201

Baltimore

1 🗌 Yes

29d. Date signed (Month, Day, Year)

Street.

31. Date filed (Month Day, Year) MAR 0 4 2008

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifie

32. Registrar's Signature

2/20/2008

street

10a. State

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Be 2

Exami

Physician/Medical

Completed

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1 Natural

29a. Certifier

31. Date filed (Month, Day, Year)

MAR 0 4 ZUUG

Certification;

Medical

State

MD

**Physician** 

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "naturat", or items 23a or any inJury or other traumatic event, the Medical Examiner must be r Baltimore, Maryland 21215-0036

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 6:30 am 03/01/2008 Delores Ann Stambaugh 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs. Prince Georges Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) (State or Foreign Months Days Hours 1 □ M 2 🛛 F Yrs **78** Washington, DC 578-34-6261 01/15/1930 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 No Laure1 Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20707 14200 Laurel Park Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify. 3 ☐ Widowed 4 A Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Book Binder **Private** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jesse B. Boling Helen Louise Chambers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1001 Graham Drive Fredericksburg, VA Diane Blesi/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) coln Cemetery 03/06/08 Brentwood, MD 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Ft. Lincoln Cemetery 03/06/08 21. Signature of Funeral Service Licensee 23a. Part1. It ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3401 Bladensburg Road, Brentwood, MD 20722 Immediate Cause (Final Cerebrovascular Accident resulting in death) Due to (or as a consequence of) Diabetes Mellitus Sequentially list conditions, if any loading Limit delicates. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Hypertension Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1☐ Yes 2 No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Linknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nown Decubitus ulcer sacrum 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D24721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14333 Laurel Bowie Road Suite 208 Laurel, MD 20708 Syed Sadiq, MD

Registrar

32. Registrar's Signature

Blow & Sparle

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 2 Day 2008 Year **Physician** George James Sheppard 4:35 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hosptial Silver Spring Montgomery 5. Social Security Number 577–64–7547 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X** M 2 □ F 61 Director 10-16-1946 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County r 28a-f show notified at show Prince George's 1 TXYes 2 ☐ No MD Mitchellville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 20721 United States 1510 Baytree Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify Specify: Black er than "natural", o 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lawyer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental F is marked Alfred James Sheppard Sammie Mae Adams 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Brenda Coleman ( sister ) 3101 Jubilee Court Huntingtown, MD 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite Pages 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) injury or Fort Lincoln Cemetery 3/9/2008 Brentwood, MD 22. Name and Address of Facility Fort Lincoln Funeral Home Signature of Fungral Service 3401 Bladensburg Road Brentwood, MD Xefred none 23a. Part1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart if lure. List only one cause on each line. Immediate Cause (Final Severe Metabolic Encephalopathy **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner certificate be executed and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4□Pregnant at time of death P.O. ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 þe Orteomyclutis of right foot 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perform certificate 2**X** No 1∐ Yes Physician: 25. Was case referred to medical examiner? T 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 1 TYes 2 ER/Outpatient 3 DOA 2 this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Certification: I or Attending F after death. Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 24 hours the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of op ျှ 3/2/2008 D 63579 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maria J. Tayag, MD 1500 Forest Glen Road Silver Spring, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2008 Registrar MAR 04 Molus

			For State Registrar	State of Maryland		artment of H rtificate of L			ene 200	08	08480
	Dhyeici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death		ear 3	3. Time of Death
	Physicia /Medic		Margaret E.	Sprouse				February	28, 200	)8 1	11:05 p <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give st Arcola Health & Re				Location of Death		4c. County of		
		ja ja	5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)		er Spring	8. Date of Birth	1		gomery e (State or Foreign
	uneral irector			M 224F 86	Yrs.	Months Days	Hours Min.	(Month, Day, Feb. 23	Year)	Country)	bama
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aryla	show ed at	'n	10a. State 10b. County		, Town or Lo						Inside City Limits 1 ☐ Yes 名冠No
the M	28a-f notifie	Director	Maryland  10e. Street and Number	Montgomery		Silver S	Spring	11	ng. Citizen of Wha		
with	3a or		901 Arcola Avenu	ıe		20902			USA		
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d 6 1 2 1 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2	item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 25€ No	Specify:	nican, etc.)		White, etc. Whit∈	
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and	n 27 i		Vincent J. Pisto			3936 Alde	rton Roa	d, Silve	r Spring	, MD	20906
Pages 1 a			20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Re	emoval from State	emetery, crei	sition (Name of matory or other plac	(e) M	arch 5,	20c. Location - Cit	ty or Town,	State
t. Pac	tant: ijury		4 ☐ Donation 5 ☐ Other (Specify)	Gat		Heaven Ce	emetery	2008 5	ilver Sp	ring,	Maryland
permit.	Important: If any Injury or once.		21. Signature of Funeral Service License			2. Name and Address rancis J. 00 Univer					MD_2090
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Phys	r this ral dir	. To	1 ☐ Yes 2 No Ho  27. Manner of Death	I I Inpatient 2 I E	ER/Outpatier 28b. Time o		4 ox inursing Ho	ome 5 Reside	nce 6 ☐Other		
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To the Hospital or Attending Physician: within 24 hours after death.	To the Funeral Director; After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examin	iclan: To the best of my know er: On the basis of examinat and manner stated.	vledge, deatl ion and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occu	and due to the ca rred at the time, da	ause(s) and mann ate and place, and	er as state d due to the	d. e cause(s)
To tl	To t	Ž	29b. Signature and title of certifier	)		29c. License	e number	29	d. Date signed (I	Month, Day	(, Year)
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			30. Name and address of person who obr	Neguss	ien	Print)	11 Spr.	ing S	A. Suit	Pri	214
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Baltimore, Maryland 21215-0036 27 is marked other

Division or Vital Records, P.O. Box 68760,

2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Maurice M. Shapiro 27, 12:03 P<sup>M</sup> 2008 February /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rockville 5809 Nicholson Lane #801 Montgomery 8. Date of Birth (Month, Day, Year)
Nov. 13, 1915 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F Yrs. 92 411-44-4184 Nov. Israel Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director MD Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or edical Examiner must be r 5809 Nicholson Lane #801 U • S • A • 14. Race - American Indian, Funeral 20852 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21☑ No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Astrophysicist U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Werner Miriam Grunberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5809 Nicholson Lane #801 Rockville, MD 20852 Ruth Shapiro - Wife : If item 27 or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 🛣 Removal from State permit. Page Department of Important: If any Injury or once. National Crematory Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 3/1/2008 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels, Inc. Dorald attemuer -1170 Rockville Pike Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused by death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Alzheimer's Dementia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Coronary Artery Disease Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Hypertension certificate has lirector, page 2 s autopsy perform 1∏ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☒ No 2 ER/Outpatient 3 ☐ D**O**A 2 funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours the Funeral Directory filled in by 4 Homicide 29a. Certifier 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29c. License number 29b Signature and title of certifier 29d. Date signed (Month, Day, Year) D41245 February 28, 2008 30. Name and address of person who completed cause of death (nem 23a) (Type, Print) Jack Epstein, MD 10810 Connecticut Avenue Kensington, MD 20895 31. Date filed (Month, Day, Year) 0 3 2008 MAR Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Rea. No.

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 MNo If Yes, Give Year or Dates:

College (1-4or 5+)

930	yland
<del></del>	 10d. Inside City Limits
	1 ∐Yes 2 TNo

9. Birthplace (State or Foreign

Charles

14. Race - American Indian,

3. Time of Death

10g. Citizen of What Country? 20646 USA

Reg. No. /

Day

2008

4c. County of Death

2. Date of Death

March

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Yes 2 ☑ No Specify: Specify: White

16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Mary Loretta Wright

Food Service Public Schools 18. Mother's Name (First, Middle, Maiden Surname)

John Cleveland Wright 19a. Informant's Name/Relationship (Type. Print)

15. Decedent's Education (Specify only highest grade completed)

6310 Hawkins Gate Road

1 ☐ Never Married 2 X Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

12

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Andrew Carroll Simpson/Husband 6310 Hawkins Gate Rd. La Plata, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State

10f. Zip Code

1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 3/10/2008 | Cheltenham, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A.

23a. Part1. Enter the disease, or compilcations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pulmonar fr510511 Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE:

10e. Street and Number

11. Marital Status

Funeral

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Completed

Be

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Examine

Physician/Medical

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Completed

Be

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Certification:

29a. Certifier

**Physician** /Medical

Examiner

the burial-transit

Records, P.O. Box 68760

Division or Vital

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🔀 No 9 ☐ Unknown

23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 1 ☐ Live birth 4□Pregnant at time of death

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

2 No

1 🗀 Yes

Year

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an 1□ Yes

autopsy performed? Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 N Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☐XNo 3□ DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation

2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and itle of certifier

29c. License number D00 33426

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Larry B. Jenkins, M.D. 111 LaGrange Ave. La Plata, MD

State Registrar

31. Date filed (Month, Day, Year) MAR 0 3 200 32. Redistrar's Signature

		-	For State Registrar	State of Ma		epartment of I Certificate of		Mental Hy	giene Reg. No.		
	sicia edica		1. Decedent's Name (First, Middle, Last)	1	Sm17	W		2. Date of De Month	Path Day	Year	3. Time of Death M
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	egyddyn.		Annapolitan  5. Social Security Number 6. Security	γ 7 Ασε	e (In yrs. last birth		napolis If Under 24 Hrs.	8 Date of Bir		Arur	
Fune Direc		-		M 2×F	87 <sup>Y</sup>	Mantha Dava		8. Date of Bir (Month, Da 1/19/	1921	Coun	ace (State or Foreign TPA
yland now	ē l	İ	10a. State 10b. County		10c. City, Town	or Location				10	Od. Inside City Limits
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or 28		Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Coun	try?
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ING Z1Z13-UU36  be filed within 72 hours after death with the Maryland tal Hygiene.  And other than "natural"; or items 23a or 28a-f show somet the Medical Evaminar muter he notified at	- Valiminal	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cub 1 ☐ Yes ※XX No		pecify Yes of No o Rican, etc.)	Specify	e - America ck, White, e	
Ind 21215-0036 be filed within 72 hours af tral Hygiene. d other than "natural", or	Medical	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed) College (1-4or 5		ecedent's Usual Occu Give kind of work done ife. DO NOT use retire	pation during most of wor ed)	king	16b. Kind of Bu	usiness/Inc	lustry
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		Be	17. Father's Name (First, Middle, Last)						e, Maiden Surnan	ne)	
Tarylan 2 should be and Mental Is marked and		၉ .	John Strojek  19a. Informant's Name/Relationship (Ty	no Defeat	106.1	delline Address (Otros	Mary St		O't T	04-4- 7/-	0-4-1
2 5 <del>2</del> 5 5			Robert Smith	Son	124	Mailing Address (Stree	d. Arnolo	d, MD 2	1012		
baltimore, permit. Pages 1 ar Department of Hea Important: If Item			20a. Method of Disposition  1  ☐ Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)		Marylan	Disposition (Name of crematory or other pland Veterans	s Cem 3/4	Date / 2008	20c. Location -		
Dalt permit. Departi	once,		21. Signature of Funeral Service Licent	'ee_Ω		22. Name and Addr		_		-	P.A.
500			23a. Part1. Enter by disease, or compleshock, or heart failure. List only of	ications that caused ne cause on each lir	the death. Do no	t enter the mode of dy	ing, such as cardiac	or respiratory a	arrest,		Approximate Interval Between
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uted	1000	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
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68/6U, flicate be ex physician a		edical		d							
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w requires that the death certiful been signed by the attending should be detached for use as		Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	cy			te of delive onth	Day Year
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ords, P.O. requires that the een signed by the	8	by P	Part II. Other significant conditions con	ntributing to death bu	ut not resulting in t	he underlying cause gi	ven in Part I.				e cause of death?
ecords law requires as been sign								10	Yes 2 No	3 Prob	ably 4 □Unknown
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Or VITA Physician: this certific		o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 □ Innatie	nt 2∏ER/Outo	atient 3 DOA Ot	26. Place of Dea	ith <i>(Check only</i> ome 5□ Res		ANI	VAPUUTME
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To the	1	M	29b. Signature and title of certifier	~ D +	2	29c. Licen	se number		29d. Date signe	d (Month,	Day, Year)
			TM Charl of	- adow l	14	リリ	21438		Jekru	ary o	18,2008
1	U		30 Name and address of person the co	ompleted cause of de	eath (Item 23a) (T	YENSE 16	H. M. A.	WAPN	1 Mm	(A)	7
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attending physician and for use as the burial-transi Records, P.O. Box 68760. signed by the atte Division or Vital

amend #5 Per FH G878 4/17/08 TH Certificate of Death

State of Maryland / Department of Health and Mental Hygiene

Reg. No. nal 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 3, 2008 08:00 AM DOROTHY MARIE CAVE SHIRLEY MAR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SCHUYLER HOUSE QUEEN ANNE'S CHURCH HILL if Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 9 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🛣 F 151-20-8824 80 Director APRIL 10, 1927 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene.
n 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at MD KENT CHESTERTOWN 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22410 GOOSE HOLLOW DR. 21620 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. þ Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME Be ( 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ WILLIAM CAVE BESSIE ROBERTS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trat once. MELINDA LIPPINCOTT/DAUGHTER 22410 GOOSE HOLLOW DR. CHESTERTOWN, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/8/2008 LAKEVIEW MEMORIAL CINNAMINSON, NJ 21. Signature of Funeral Service Licenses 22. Name and Address of Facili FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part1. Enter the disease, if completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** advanced disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ÎNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 1.11Mlun . M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave, Chestertown, MD. 21620 KINK. WUN, 415 Washington 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 5 2008 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Paul 31. Date filed (Month, Day, Year) FEB 2 9 2008

JOHN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St. Salishury MD

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r	₩ 3		Registrar  1. Decedent's Name (First, Middle, La		-061	inicate of L	Jeani	2. Date of Dea	- tom W	3. Time of Death
	Physici			hard Schorm	1			Month March	11, 2008 Year	
	/Medic Examir		4a. Facility Name (If not institution, given			4b. City, Town, or	Location of Death	, naren	4c. County of D	
			Calvert Memoria	al Hospital		Prin	ce Frede	rick	Calv	ert
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. las	- /	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day April	. Year) 9.1	Birthplace (State or Foreign
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	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, 1	Town or Lo	cation				10d. Inside City Limits
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	28a-	Director	10e. Street and Number	darvere	onesa	10f. Zip Code	CII		0g. Citizen of What	
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	be filed within 72 hours after death with the Maryland that Hygiene.  dother than "natural", or items 23a or 28a-f show event, the Mediral Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. \	Was Decedent of His f Yes, specify Cuba	20121			merican Indian,
2	after or iter		1 ☐ Never Married 2 🛣 Married	Armed Forces?  1 Tyes 2 No If Yes, Give 1049-5	1			Rican, etc.)	Black, W	
21215-0036	ral", c	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1948-5	53	1∐Yes 2∭∭ No	Specify:		Specify:	white
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Maryland	ould be fi Mental H arked otl atic ever	Be	17. Father's Name (First, Middle, Last	,				,	Maiden Surname)	
N	hould d Me mark maric	은	Paul F.  19a. Informant's Name/Relationship	Schorm	10b Mailin	a Address (Street a	Evely:		txwe11 r, City or Town, Stat	a Zio Codol
Ma	es 1 and 2 should b of Health and Ment item 27 is marked r other traumatic e		Mary G. Schorm,						Beach, MD	00700
ē,	Heal Heal tem 2		20a. Method of Disposition	20b. Plac	e of Dispo	sition (Name of	T		20c. Location - City	
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	- 4		23a. Part1. Enter the disease, or com shock, or heart failure List only	pplications that caused the death.						Approximate Interval Between
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	/Medical		disease or condition resulting in death)	a. Due to (or as a consequer		.,-0.0,,,,	( ) ( )	7	2/02/100	
14	Examiner		Composite lies and distance	h						
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	ite of):					
To	ecute and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	С.						
,0928	cate be executed physician and the burial-transit		and down, 240.	Due to (or as a consequen	ice of):					
87	physic the t	dical		d						
9 X	the death certific y the attending p iched for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome pf pregnance	v				004 0-4-4	delbases
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal de	eath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	Day Year
P.0.	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	5	Other (specify)				
	res that the de igned by the a be detached	Y Ph	Part II. Other significant conditions	contributing to death but not resulting	ng in the ur	iderlying cause give	n in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
rds	requires that een signed b nould be deta	d by						1 <b>2</b> Y	es 2⊡No 3⊡	Probably 4 Unknown
000	> 9 0	Completed						24a. Was a	ın 24b. Were	autopsy findings available
æ	e – e	mo	<del>* · · ·</del>					autops	med?   death	to completion of cause of
<u>ra</u>	(0 -	Be C	25. Was case referred to medical				26. Place of Deat			′es 2 □ No
>	is cel	To B	examiner? 1  Yes 2 <b>X</b> No	Hospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatien	t 3 DOA Othe	r.		ence 6 Other (S	pecify)
0	Attending Physiclan: r death. ector: After this certific by the funeral director,		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	Bb. Time of Injury	28c. Injury Work			ow injury occurred	
<u>Ö</u>	endir or: Air he fu	atic	2 ☐ Accident investigation	n			res 2 □ No			
Division or Vital Records,	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		e, farm, stre	eet, factory, office	1	28f. Location (Si City or Town		Rural Route Number,
Ω	To the Hospital or Attending Physician: within 24 hours after deals.  To the Funeral Director: After this certific completely filled in by the funeral director,									
	Hosp 4 hou Fune tely fi	Medical	(Check only 2 Medical Exa	nysician: To the best of my knowle miner: On the basis of examination	edge, death n and/or inv	occurred at the time restigation, in my op	ne, date and place, pinion, death occur	and due to the or red at the time, or	ause(s) and manner date and place, and	as stated. due to the cause(s)
	thin 2 the mple	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License	number		29d Data signed (M	onth Day Year)
	1 × 1 0	-	Detr.	mand an	٨		0370		29d. Date signed (M	108
7		ł	30. Name and address of person who	completed cause of death (Item 23					0/10	10-
	1011		Peter L. Wisniev	,	, , , , .		# 310. P	rince Fr	rederick	MD 20678
1	Sta	te	31. Date filed "(Month, Day, Year)	32. Registrar's Signatur			<b>,</b> -			
	Registr	_	MAR 1 7 200	8 Bedie St.,						

	1		Please	Type or Print in State of Maryla						egible.	
			1 - State Registrar		Cei	rtificate of	Death	1	Reg. No.	008	08491
9	Physic		1. Decedent's Name (First, Middle, Las Feyissa Ts	sig <b>e</b> marian				2. Date of De		08 Year	3. Time of Death 1729 M
	/Medi Exami		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	or Location of Death		4c. Cc	ounty of Death	
			Holy Cross Hospi	tal		Silver	Spring		Мо	ntgome	rv
	Funeral Director	2	5. Social Security Number 6. S		ors. last birthday) O Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min,	8. Date of Birt (Month, Da 02/27/	h Y, <u>Ye</u> ar) 1,978	9. Birthp Cour Etho	place (State or Foreign http:) pia
	and w		Usual Residence of Decedent  10a. State 10b, County	10c.	City, Town or Lo	cation	•				10d. Inside City Limits
	f sho	ō	Md. Montgon		Silver						1. Yes 2 No
	the A	ect	10e. Street and Number		OTTVOL	10f. Zip Code			10a. Citizer	n of What Cour	ntry?
	th with 23a or ust be	ral Di	11469 Columbia F	ike		20904			_	opia	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 ☒ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 점 No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 점 No	Hispanic Origin? (Special, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		Black, White, Blecify: B16	etc.
Õ	72 hor	ted	15. Decedent's Ed (Specify only highest gra	ducation	16a. Dece	dent's Usual Occu	pation	ina	16b. Kind	of Business/In	dustry
21215-0036	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of worki	,,,g	Doo	6- 0	-
21	ed wi	ပ်		1	Wa	itress	1.0.1.0.1.1.1	(F)		taurant	<u>-</u>
Maryland	ould be fil Mental H arked otl	To Be	17. Father's Name (First, Middle, Last) Ketema Feyissa				18. Mother's Name Yesewde			irname)	
lan,	2 sho and i is ma	- 8	19a. Informant's Name/Relationship (	Type. Print)			t and Number or Rura				
	and lealth m 27	1	Gizachew Giya	(Friend)			Street,			<u> </u>	OC 20011
Baltimore,	Pages 1 nent of H ant: If ite		20a. Method of Disposition  1 ★ Burial 2 Cremation 3  4 Donation 5 Other (Specif.	Removal from State		nsition (Name of matory or other pla 7 Cemeter	ice) 2/12/	2008		tion - City or To .s Ab <b>a</b> ba	own, State A, Ethiopi
Balt	permit. Departr Imports any inji		21. Signature of Funeral Service Licer	Bacon, CC	36/34	Name and Address W. H.Bac 47 14th	ess of Facility on Funera Street, N	1 Home, .W. Wa	Inc.	ton, DO	20010
	<b>8</b> –		23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.	eath. Do not ent	er the mode of dyi	ing, such as cardiac				Approximate Interval Between Onset and Death
8	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Cerebral		ith br <b>a</b> i	n death				48 hrs
	Examiner			Due to (or as a cons		ive Free	nhalitic				one week
25		ie e	Sequentially list conditions, f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Rapidly Progressive Encephalitis  Due to (or as a consequence of):						one week
	utec	틆	cause. Enter Underlying Cause (Disease or injury	Acquired	Immunod	eficienc	y Syndrome	2		9	years
Ć,	e executed sian and urial-transi	Examiner	that initiated events resulting in death) Last	Due to (or as a cons			, ,				
68760,	ite be iysicia ne bur	ical	(	d							
O. Box 68	the death certificate be executed in the attending physician and ched for use as the burial-transition.	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	Ectopic pregnand Other (specify)	sy		230	d. Date of delive	ery Day Year
٩	ires that the de signed by the a l be detached f	by	Part II. Other significant conditions of	contributing to death but not							he cause of death?
Records,	e law requires been seen seen seen seen seen seen se	Completed						24a. Was	an :	24b. Were auto	opsy findings available
<u>a</u>	iclan: Th certificate ector, pag		OF Was assessed to madical					1□ Yes	24□ No	1 ☐ Yes	22 No
Vital	Physiclan: this certificral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital: 1 XInpatient 2	⊇ ☐ ER/Outpatier	nt 3 DOA Oti	26. Place of Death			70 (0	
o	Phy er this eral di		27. Manner of Death	28a. Date of Injury	28b. Time of		ry_at Nursing Ho	me 5 ⊔ Resi 28d. Describe I			<i>fy)</i>
on	Attending Phyrdeath. ector: After thi	tion	12⊈ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year	r) Injury		rk? ]Yes 2 □ No				
Division	I or Attendater death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - A building, etc. (Spe	t home, farm, str ecify)	eet, factory, office		28f. Location (S City or To	Street and I vn, State)	Number or Run	al Route Number,
	o the Hospital or Attenithin 24 hours after death other Funeral Director: on the Funeral Director: ompletely filled in by the	Medical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, death ination and/or in	h occurred at the t vestigation, in my	ime, date and place, opinion, death occur	and due to the red at the time,	cause(s) ar date and pl	nd manner as s lace, and due t	stated. to the cause(s)
	o the vithin 2 o the complet	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date s	signed (Month,	Day, Year)

Neith Com

31. Date filed (Month, Day, Year) State Registrar

Shailesh Sheth, M.D . 1500 Forest Glen 32. Registrar's Signature

30. Name and address of person was completed cause of death (Item 23a) (Type, Print)

MAR 0 4 2008

D52503

February 29, 2008

Silver Spring, Md. 20910

		State of Maryland / De	•		ental Hyg	giene	0.01.01	
186		1 - State RegIstrar  1. Decedent's Name (First, Middle, Last)	ertificate of Dea		2. Date of Dea	Reg. No. 2 0 8	3. Time of Death	
Physici	an	JOAN M. THOMPSON			Month	Day Year		
/Medio Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Locat		ren.	26 , 2008 4c. County of Death	1:05A "	
LAGIIIII	ici	Holy Cross Hospital	Silver Sp	pring		Montgor	nerv	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Months Days Hou	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day	n 9. Birth	place (State or Foreign intry)	
Director		213-42-0002 66			Dec.		Vash, DC	
land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits	
Mary I-f sh	to	MD Montgomery Silve	r Spring				1 Yes 2 No	
th the or 28%	Director	10e. Street and Number	10f. Zip Code			10g. Citizen of What Cou	intry?	
ath wi	ral	11501 February Circle	20904			U.S.A.		
er dea items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	<ol><li>Was Decedent of Hispanio If Yes, specify Cuban, Mer</li></ol>	ic Origin? (Spec exican, Puerto R	rify Yes or No- lican, etc.)	14. Race - Amer Black, White		
ING Z1Z13-UU3D  be filed within 72 hours after death with the Maryland that Hygiene.  cd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔼 No If Yes, Give 9 Year or Dates:	1 ☐ Yes 200Mo Spe	ecify:		Specify: B	Lack	
5-UU36 72 hours af natural", or dical Exami	ted	15. Decedent's Education 16a. De	cedent's Usual Occupation		1	16b. Kind of Business/I	ndustry	
3 60	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)	ive kind of work done during e. DO NOT use retired)	most of working	9	$W\Delta T.M\Delta DT$	WALMART	
d Z1Z1	ပ္ပြ		intanence	detherds blows	/Fine Bainty		•	
Viano vuld be file Mental H arked oth	Be	17. Father's Name (First, Middle, Last)	18. M			Maiden Surname) Shington		
L EDFF	မ	Frank Matthews  19a. Informant's Name/Relationship (Type. Print)  19b. M	ailing Address (Street and Nu	lumber or Bural	Route Numbe	er. City or Town State 7	in Code)	
Malind 2 slatth an 27 is retraur		Tina Smith-Daughter 139	50 Dalmer H	louge I	War Ci	lvor Cori	20904	
S 1 ar			59 Palmer H sposition (Name of crematory or other place)	Da	ate Tay	20c. Location - City or	rown, State	
Page Page nent c int: if		1 Laburiai 2 Ucremation 3 Liternoval from State	erans Cem	3/5/0		Crownsvil		
baltimore, IVI permit. Pages 1 and 2 Department of Health a Important: If flem 27 is any injury or other tra once.		21. Signature of Funeral Trivice Licens	22. Name and Address of F	acility Sno	owden	Funeral H	lome, PA	
D SQEES	_	Leer ynaul	246 N. Wash				•	
		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, suc	ch as cardiac or	respiratory ari	rest,	Approximate Interval Between Onset and Death	
Physician /Medical		Immediate Cause (Fin disease or condition resulting in death)  a. Chronic Obstr	uctive Fulm	onary	Disea	se		
Examiner		Due to (or as a consequence of):  Pneumonia						
<u>.</u>	Jer	Sequentially list conditions, if any, leading to immediate b.  Due to (or selections of consequence of):						
cuted od ransit	Examiner	rany, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
oc exe sian al urial-t	EX	resulting in death) Last  Due to (or as a consequence of):						
68/60, ficate be executed physician and s the burial-transit	dical	d	· · · · · · · · · · · · · · · · · · ·					
COIGS, P.O. BOX by requires that the death certific been signed by the attending I should be detached for use as		IF FEMALE: 23c. If yes, outcome pf pregnancy				23d. Date of deli	verv	
requires that the death certifeen signed by the attending hould be detached for use as	Physician/Me	25b. Was decedent pregram in the past 12 months?  1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year	
t the c	hysi	9 Unknown 9 Unknown						
S, F	by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in P	Part I.	23e. Did to	bacco use contribute to	the cause of death?	
ecords, faw requires t as been signe 2 should be o		Respiratory Failure			1 U Y	∕es 2 No 3 Pro	obably 4 X Unknown	
2 8 2	ple	Hypotension			24a. Was a autop	sy prior to c	topsy findings available ompletion of cause of	
VITAI HEC ician: The law certificate has I ector, page 2 s	Completed					rmed? death? 2 ☑No 1 ☐ Yes	<b>≱</b> No	
Or Vital I Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:	Other:	Place of Death				
on or ding Phys h. h. After this controlled in the control of the	- To	27. Manner of Death 28a. Date of Injury 28b. Tim	e of 28c. Injury at			dence 6 Other (Spectors)	cify)	
nding nding th.	tion	1 ☐ Natural 5 ☐ Pending (Month, Day Year) Inju	ry Work? M 1 ☐ Yes	2 🗆 No				
DIVISION of all or Attending F after death. I Director: After de in by the funeral of in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide  4 ☐ Could not be determined  28e. Place of injury - At home, farm building, etc. (Specify)	street, factory, office	2	8f. Location (S City or Tow	Street and Number or Ru	ral Route Number,	
ital or rs after ral Di	Ser	E.E.		1				
DIVISION  To the Hospital or Attenwithin 24 hours after death  To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, do 2 ☐ Medical Examiner: On the basis of examination and/cone) and manner stated.	eath occurred at the time, da or investigation, in my opinion	ate and place, a n, death occurre	nd due to the o	cause(s) and manner as date and place, and due	stated. to the cause(s)	
o the ithin i	Med	29b. Signature and title of certifier	29c. License numl	nber	:	29d. Date signed (Montl	n, Day, Year)	
1		I Anand Demarine	D624	75		2/26/6	8	
		30. Name and address of person who completed cause of death (Item 23a) (Ty				2 / 2 3 / 3 (	/	
		Anand Deonarine, MD 1500 Fore	st Glen Rd	Silve	r Spr	ing, MD 2	0910	
Sta Regist	ate	31. Date filed (Month, Day, Year)  MAR 0 3 2008	harts)					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death v 18 2008 February Beatriss W. Turner 5:30A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie Health & Rehab Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months 1 □ M 2 ▼ F 87 212-28-6649 May 1920 Maryland 10 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Anne Arundel Arnold 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1208 Jones Station Rd. 21012 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2x ☐ No Specify Specify: Black 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th 2yrs LPN Crownsville Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Woodard Florence Chase 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph Turner(Son) 1208 Jones Station Rd. Arnold, Md. 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) Calvary UMC 2-25-08 Arnold, Md. 21. Signature of Funeral Service Licensee WinName Redection of Sacilisons Mortuary, P.A. Tarry B. Keese MOOY8 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 XUnknown

**Physician** /Medical **Examiner** 

Physician

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notifled at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be n

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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y physician and as the burial-transit Physician/Medical as use ed by the a detached f signed to 2 Completed page 2 Be

requires that the death certificate be executed

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the Hospital or Attending in 24 hours after vec... the Funeral Director: Aft <sup>2</sup>

Certification:

Division or Vital Records, P.O. Box 68760,

IF FEMALE 23b. Was decedent pregnant

> 24a. Was an autopsy performed? 2 No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25	. Was case referred to medical	26. Place of Death (Check only one)							
	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)						
27	. Manner of Death  1 Manural 5 ☐ Pending 2 ☐ Accident investigation		28d. Describe how injury occurred						
	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
-00	- Cartifica I Montificia Di	and the best of th							

(Check only

the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

FEB 2 9 2008

29c. License number D-40521 29d. Date signed (Month, Day, Year) 27,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. OCHANES

325 HOSPITAL mite 208

State Registrar

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Day 15, ZVOS Physician Theodore J. Thomas /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Co) em Bur Anny Brund 21 からも BWMC If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth NOV 5 1932 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1√2 M 2□ F Maryland 217-24-6386 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10h. County 10d. Inside City Limits show ms 23a or 28a-f shov must be notified at 1X Yes 2 □ No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1902 C Copeland St. 21401 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, r than "natural", or Items the Medical Examiner me 11. Marital Status Black, White, etc. filed within 72 hours after 1 X Yes 2 No
If Yes, Give
Year or Dates: 1952-53 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4or 5+) Pepsi Cola Co. Supervisor 11th Ò 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be and Mental Ida Taylor Randolph Thomas 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trau Sarah E. Thomas(Wife) 1902 C Copeland St. Annapolis, Md. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State 2-20-08 Maryland Veteran Crownsville, Md. 4 □ Donation 5 □ Other (Specify) AMiame Repose of AciliSons Mortuary, T.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 . Treese MO048 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Congestive /Medical Due to (or a //a consequence of): Examiner Caquernally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): led by the attending physician detached for use as the hura P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No autopsy performed? 'es 2 No this certificate 1□ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Inpatient To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After thi completely filled in by the funeral i 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11480 UX

State Registrar

31. Date filed (Month,

12

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2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		For	State of Maryla	-			Mental Hy	giene	all all all	
A. T.		1 - State Registrar		Ce	ertificate of	Death		Reg. No	008	08494
Physicia /Medic		1. Decement's Name (First, Middle, Las	"Wilmore	Tin	ch		2. Date of De	Day	2008	3. Time of Death
Examin		4a. Facility Name (If not institution, give	street and number)	CAR	4b. City, Town, o	Location of Dea	ith	4c. Co	unty of Death	
Funeral		5. Social Security Number 6. S	7. Age (In yr.	s. last birthda		If Under 24 Hr		th ,	9. Birth	place (State or Foreign
Director		2.04.24.2471	□ M 2 <b>X</b> F	77 Yrs.	Months Days	Hours Mir	12 Q	y, Year)	Cou	ntry) ワD
and t		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or I	ocation					10d. Inside City Limits
Maryl I-f sho	tor	mp tent	G	alen	6					1 XYes 2 □ No
death with the Maryland ms 23a or 28a-f show r must be notified at	Director	10e. Street and Number		14 0 -11	10f. Zip Code			10g. Citizer	of What Cou	ntry?
ath wi	ral	107 WEST Cross						Ш		
ter de items iner n	Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Married</li></ul>	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No	U.S.   13	. Was Decedent of H If Yes, specify Cuba	ispanic Origin? ( an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	) 14.	Race - Ameri Black, White,	
be filed within 72 hours after death w tial Hygiene. d other than "natural", or items 23a event, the Medical Examiner must b	þ	3 MWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗷 No	Specify:		Sp	pecify: 3/	cx
72 hc	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Giv	edent's Usual Occup	during most of w	orking	16b. Kind	of Business/In	ndustry
within ene. than '	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	i) -		C14887	Ten Ru	ERMANOR
e filed Il Hygi other /ent, t	Be Co	17. Father's Name (First, Middle, Last)	~		21146	18. Mother's Na	ame (First, Middle			acryance
	10 E	WATSON WILMON	ee			Edit	4 HAN	1CE		
s 1 and 2 should be filed within 'f Health and Mental Hyglene. Ifem 27 is marked other than "fem cother traumatic event, the Mec		19a. Informant's Name/Relationship (7			ling Address (Street	and Number or F	Rural Route Numb	er, City or To		/
1 and Health em 27		20a. Method of Disposition		Place of Dis	DEISTOLO position (Name of ematory or other place	AY MEU	) CAS 7/ E	20c. Locat	19720 ion - City or T	own. State
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra		1 ■ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		cemetery, cr	ernatory or other plac	:e) ;		,		
permit. I Departm Importar any Injui		21. Signar re of Funeral Service Licen	see	47071277	22. Name and Addre	ss of Facility	Enneth W	SALLEY	Funer	D U SERVIČE
<b>8 3 5 6</b> 6		Juce O. Wa	cley (woo	026) 8	21 WEST ST	TREET A	nnapolis	mo	2/40,	/
		23a. /af1. Enter the disease, or complete the complete control of the control of	lications that caused the dea one cause on each line.	ath. Do not e	nter the mode of dyir	ig, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Myous Due to (or as a conse	dias	interv	ria				2 h-02
Examiner				equence ot):						
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be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conse	autence of).						
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tificate ng phys as the	ledic		d							
teath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fe	tal death 3	□Ectopic pregnancy	,		23d	Date of deliv	ery Day Year
The law requires that the death certificate ate has been signed by the attending phystoage 2 should be detached for use as the	Physician/Me	1 ☐ Yes ZE No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5	Other (specify)				WOTE	Day Tour
w requires that the d been signed by the should be detached		Part II. Other significant conditions of		-		en in Part I.	23e. Did t	obacco use	contribute to t	the cause of death?
eduires en sig ould be	ed b	Hypertension.	Cerebroy	ascula	o dis.		1 🗆	Yes 2D	No 3 □ Pro	bably 4 □Unknown
law re as be	Completed by	Type I Dak	etes GE	20			24a. Was			opsy findings available
								rmed? 2 No	death? 1 ∐ Yes	213No
siciar certif irector	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient	TER/Outpatie	ent 3 DOA Othe	or:	eath (Check only o		70.1. (a. 1	3
g Phy ter this neral d	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time Injury	III OLI DON	4 LI Nursing	Home 5 Resi			TY)
endin eath. or: Af the fur	atio	1 Suicide 5 Pending investigation 3 Suicide 6 Could not be	(Month, Day You)	III,uiy		Yes 2□No				
or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At I building, etc. (Spec	home, farm, s cify)	treet, factory, office		28f. Location (: City or To		lumber or Run	al Route Number,
		29a. Certifier  (Check only 2 Medical Exam	/sician: To the best of my kr	nowledge, dea	th occurred at the tir	ne, date and pla	ce, and due to the	cause(s) an	d manner as	stated.
the Hollin 24	edical	one)	iner: On the basis of examir and manner stated.	nation and/or			curred at the time,			
To viti	Σ	29b. Signature and title of certifier			29c. Licens	5173	6	29d. Date s	igned (Month,	Day, Year)
3	-	30. Name and address of person who	ompleted cause of death (Ite	em 23a) (Tvos		3113	,	5	2 08	5
ms		Frederick DEI	boy mo 6	6020	churchh.	11 Rd Cr	restertou	sa mi	216	20
Stat		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	South &		31			
Registra IMH 17 Rev 1/20		MAR 0 4	32. Registrar's Sign	5 9	A STATE OF THE PARTY OF THE PAR					
/ 1104 1/20	- 1									

#### 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 22, 2008 Rachel Ann Taylor /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🗓 F 91Yrs 218-58-7908 20, Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10a. State 10b. County Director Penna. York York 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1775 Powder Mill Road 17403 United States Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be James A. Gifford 2 19a. Informant's Name/Relationship (Type. Print) Margaret E. Taylor - daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Brick Meeting 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 27, 4 Donation 5 Other (Specify) House Cemeter 21. Signature of Funeral Service Licens M01072 934 South Main Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Aspiration Pneumonia Physician resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and as the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 the attending physician by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 5 Other (specify) detached 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementi Completed has certificate 1∐ Yes 25. Was case referred to medical examiner? Be 1 ☐ Yes 2 No 1 \(\int\)Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this filled in by the funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? To the Hospital or Attending F within 24 hours after death. To the Funeral Director; After (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Kalkon

Amended Items 23a, Part I & 29d per Physician 02/28/2008 Carroll Co. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. wil State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Elizabeth Cunningham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18162 Ridge Meadow Road Stewartstown, PA 17363 20c. Location - City or Town, State Rising Sun, Maryland 22. Name and Address of Facility Eline Funeral Home Hampstead, Maryland 21074 3 Orbital Between 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2□10 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) February 22, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 32. Regintrar's Signature **ORIGINAL** 

3. Time of Death

4:33

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 ☐ Yes 2√∑ No

4c. County of Death

Baltimore

1916 Maryland

14. Race - American Indian.

Black, White, etc.

Specify: white

 $\mathbf{P}^{\mathsf{M}}$ 

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

28

FEB

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		1 - State Registrar	Cei	rtificate of L	Death		Reg. No. 2	008	0.6496
Dhyoio	ion	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	eath Day	Year	3. Time of Death
Physic /Medi		Catherine Elizabeth	Tosto	n		Feb.		2008	11:10a <sup>M</sup>
Exami	ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. Cou	nty of Death	
		1939 Harvey Gummel Road		Hampste				Car	
Funeral		1 □ M 2 □ F	. last birthday) Yrs.	If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Da	ay, Year)	Cou	place (State or Foreign intry)
Director		218-42-0592	*****			9/19/1	943	MD	
land ow			ity, Town or Lo	cation					10d. Inside City Limits
Mary f sho	Ö		TT						1 □Yes 2 □No
the 28a	Director	MD Carroll  10e. Street and Number	нащ	ostead 10f. Zip Code			10g. Citizen	of What Cou	
3a ol	0	1939 Harvey Gummel Road		21074			USA		
death ms 2	Funeral	11 Marital Status 12. Was Decedent Ever in	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or N	)- 14. F	Race - Amer	
or ite	Fu	Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give	1	il res, specily cuba 1 □ Yes 2 ☑ No	Specify:	nican, etc.)		Black, White	
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dygie her t		11 17. Father's Name ( <i>First, Middle, Last</i> )		COOK	18. Mother's Name				
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d 2 s d 2 s than 17 is u		Michael K. Toston, Sr. husbar							
ie, with y failed Z 12 10 0000			Place of Dispo	sition (Name of	1	Date		on - City or T	
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artme ortan injur				Cremation  2. Name and Addres					rw.
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau		I Standa L'hemmer	93	34 So. Mai	in St., H	lampste	ad, Md.	2107	4
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ysici is cer direc	To B	examiner? 1 ☐ Yes No Hospital: 1 ☐ Inpatient 2[	☐ ER/Outpatier	nt 3 DOA Othe	er: 4 Nursing Ho	me KRes	idence 6 □	Other (Spec	ify)
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or Att ter de lirect n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office		28f. Location City or To	(Street and No wn, State)	ımber or Ru	ral Route Number,
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To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for use	Me	29b. Signature)and title of certifier	1.0	29c. License	number		29d. Date si	gned (Month	n, Day, Year)
->-0		Darah (1) Mattall	MD	2000	2400		2/25	5/ AC	08
MIL		30. Name and address of person who completed cause of death (Ite	em 23a) (Ţ <u>y</u> pe,	Print) ,			0.70.0	1000	-0
5		Sarah Fra Hali MD 423/North	waads 7	Trail Ha	mpskad	MD	21074		
	ate	31. Date filed (Month, Day, Year) 32. Regierar's Sign		1 4					
Regist	rar	FEB 2 6 2008 Mesers	15	GOBALL					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** STEPHEN SCOT TACKISH SR. <u>7:4</u>5₽<sup>™</sup> MARCH 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death FORT WASHINGTON HOSPITAL PRINCE GEORGE'S FORT WASHINGTON If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days TXIM 2□ F 578-84-6426 Yrs Director 48 MAR.18,1959 WASHINGTON, DC Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD CHARLES WALDORF 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3180 EUTAW FOREST DRIVE 20603 S. Funeral Α. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ 3 Widowed 4 Divorced Year or Dates: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) COMMERCIAL Elementary/Secondary (0-12) College (1-4or 5+) CONTRACTS MANAGER CONSTRUCTION any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I ant: If item 27 is marked o PAUL TACKISH GLORIA E. GRAVES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN A. TACKISH/WIFE 3180 EUTAW FOREST DR. WALDORF, MD 2060 20c. Location - City or Town, State MD 20603

20b. Place of Disposition (Name of cemetery, crematory or other place)

METROPOLITAN CR.

Date

ALEXANDRIA, VA

15,2008

MARCH

**Physician** /Medica Examiner

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Registrar's Signature

4 □ Donation 5 □ Other (Specify)

Division or Vital Records, P.O. Box 68760

		THE THOU OF OTHER		UVO AL	CVWNDK?	LA, VA
	21. Signature of Funeral Service License	e 1 22. Nam	ne and Address of Facility D ∧ V	מווש כומסאי	T CEDUT	י כו די
	Yound Isa	F 631	ne and Address of Facility RAY	MOND FON	n.sekv.	ICE, P.A.
	CO. Post Foto No discos a comple	7	1 WASHINGION	AVE. LA	PLATA,	MD20646 Approximate
	shock, or heart failure. List only on	cations that caused the death. Do not enter the e cause on each line.	mode of dying, such as cardiac of	or respiratory arrest,		Interval Between
ı	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	Beart Dis	lense		Onset and Death
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence of):	.0~			
Xa	resulting in death) Last	Due to (or as a consequence of):				-
Ш						
3	d.					
ed						
1	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome pf pregnancy			23d. Date of de	livery
<u>a</u>	in the past 12 months?		pic pregnancy er <i>(specify)</i>		Month	Day Year
Sign	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	(specify)			
بخ						
<u>&gt;</u>	Part II. Other significant conditions con	tributing to death but not resulting in the underlyi	ing cause given in Part i.			the cause of death?
Completed by Physician/Medical				1 🗆 Yes	2 □ No 3 □ Pi	robably 4 Unknown
e e				24a. Was an	24b. Were au	utopsy findings available completion of cause of
를				autopsy performed	death?	
ပိ				1□ Yes 2	lo 1 ☐ Yes	2 □ No
Be	25. Was case referred to medical examiner?		26. Place of Death	n (Check only one)		
10	1 ☐ Yes 2 No	ospital: 1 ☐ inpatient 2 ER/Outpatient 3 ☐	☐ DOA Other: 4☐ Nursing Ho	me 5 🗆 Residence	6 ☐Other (Spe	ecify)
ΙĘ	27. Manner of Death	28a. Date of Injury 28b. Time of		28d. Describe how inj		
<u>.</u>	1 Natural 5 Pending investigation	(Month, Day Year) injury				
Sa	2 Accident investigation 3 Suicide 6 Could not be			00f 1 time / (04 4	and Month on the D	
Medical Certification:	4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or City or Town, State)			and Number or Hi ite)	urai Houte Number,
a	29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge, death occu	rred at the time, date and place,	and due to the cause	(s) and manner as	s stated.
dic	(Check only 2 Medical Examin	er: On the basis of examination and/or investigand manner stated.	ation, in my opinion, death occur	red at the time, date a	nd place, and due	e to the cause(s)
₩ Me	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Mont	th. Dav. Year)
	1) caha	1-0		2		
	N Carlo	~~~~	DAAEA722	-	1 91 05	/

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State

Registrar

31. Date filed (Month, Day, Year)

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

D0054723

R2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AVEN TIEW 24a 26 per VERB 3877 3/17/08 VS
State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Vear ALISHIA VIRGINIA VAUGHAN 3 0545 /Medical 9 Z008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Hayland Medical Center 5. Social Security Number / 6. Sex | 7. Age (In yrs. last be 7. Age (In yrs. last birthday) If Under 1 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 💢 F 215-15-4620 Director 20 18/1987 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M-dical Examiner must be notified at 1 ☐Yes 2 No Director PA. Lancaster Holtwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 75 Bethesda Church Road 17532 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Completed by Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Alishia Vaughan Elementary/Secondary (0-12) College (1-4or 5+) 3 months Certified Nursing Asst. Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Vaughan ည Jr. Carolyn Virginia Dorn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State PA Code) 17566 19a. Informant's Name/Relationship (Type. PrintMother) Carolyn D. Ferreira 1126 Fishing Creek Hollow Rd. Quarryville, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Dother (Specify) Jarrettsville Cem. 3/13/2008 Jarrettsville, MD. 21. Signature of Funeral Service Light ee 22. Name and Address of Facility Jarrettsville, Maryland lder E.G. Kurtz & Son Funeral Home. P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Brain Injun Traumatic disease or condition resulting in death) 12 hrs. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit CENTERATION APPROVED BY MEDICAL EXAMINE and Due to (or as a consequence of): P.O. Box 68760, aftending physician for use as the buria the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year signed by the a 4☐Pregnant at time of death 5 ☐ Other (specify) 1☐Yes 2☐No 9☐Unknown 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tes Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has le 2 autopsy performed?

1 Yes 2 XNo this certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence • Hother (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA within 24 hours after useum.

To the Funeral Director: After the committee of filled in by the funeral 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 1 Natural 5 Pending investigation 3/8/08 1 ☐ Yes 2 ☑ No 2 Accident 1700 Notor Vehicle Crash 3 Suicide 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) Koute 136 PyleSville, Man 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide determined street 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/9/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 Street, Ba Himare, MD S. Greene 32 Registrar's Signature 31. Date filed (Month, Day, Year). 2008 State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CARRELL Ε. WEISS February 29 2008 8:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SANDY SPRING MONTGOMERY FRIENDS NURSING HOME If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🗷 F 392 12 9592 Director 85 Wisconsin 4,1922 April Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director MD. 1 Yes 2 No Montgomery 01ney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4424 Morningwood Drive or iteme 23a 20832 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 S No Specify: ۵ Yes, Give Specify: White 3 XWidowed 4 □ Divorced "neturel". Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Itam 27 is marked other then "no eny injury or other traumatic event, Itam Media once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 Homema ker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Wilford Nehmer Ernestine Riesch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christianne L. Caffee,Daughter 4424 Morningwood Drive, Olney, Md. 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Parklawn Cemetery 3/8/08 Rockville, Md 21. Signature of Funeral Service Licenses 22. Marrand 1 ddrgss of Barber Funeral Home mariet H. Barber P.O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Failure to Thrive resulting in death) /Medical Due to (or as a consequence of) Examiner Hyperlipidemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit Hypothyroidism the attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) deteched 9□ Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 99 1 ☐ Yes 2 SNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Director: After 1 SNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after Hospitei within 24 hours a 29a, Certifie 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ihe. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060089. lulolli 29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13975 Connecticut Ave., #202, Silver Spring, Md. 20906 Ramani B. Reddy, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 03 2008 Registrar

			1- State of Maryland / Department / Department / Department / Department / Department / Departme	rtificate of Death		e •oaaa	00500
ŀ	Physici	an	1. Decedent's Name (First, Middle, Last)  Kareem Lateefe Whren		2. Date of Death Control 24,	2000	3. Time of Death 0349 a M
6/15.00	/Medio	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death	
-		i,	Southern Maryland Hospital	Clinton	0 D : (B'H	₽G	
3/5	Funeral Director		5. Social Security Number  577–98–2486  Usual Residence of Decedent  6. Sex  1	If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year 05/17/1974	r) Cour	place (State or Foreign stry)  gtan, D.C.
	yland now at		10a. State 10b. County 10c. City, Town or Lo			1	0d. Inside City Limits
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	ath with the 23a or 2 ust be no	Funeral Director	301 - 34th Street, S.E. #1	10f. Zip Code 20019	Ţ	itizen of What Cour	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married 1 Yes 2 XNo	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 ☑ No Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Black	etc.
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Mary	und 2 shou alth and M 27 is mar er traumat			ng Address (Street and Number or Rura 34th Street, S.E. #1; V			
Baltimore, Maryland 21215-0036	Pages 1 ament of He ant; If item ury or oth		4 □ Donation 5 □ Other (Specify)	matory or other place) morrial Park 03/08,	/2008 Lan	bover, Mary	land
Balt	permit. Departi Import any inj once.		21. Signature of Juneral Service Licensee 22	2. Name and Address of Facility Free 594 Beech Road; Temple	man Funeral : Hills, Mary	Services land 20748	
١			23a. Part. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
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Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  Fo the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Completed by			24a. Was an autopsy performed? 1  Yes 2  ☑	/ death?	opsy findings available impletion of cause of
<u>ta</u>	ctor, p	Be C	25. Was case referred to medical examiner?	26. Place of Death		10 10163	ZUNO
<u>o</u>	Physic this or	၉	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatien		ne 5 Residence		fy)
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	withii comp	M	29b. Signature and title of certifier	29c. License number		ate signed (Month,	
)			James James	P62200	10	6,25,	2008
	D		30. Name and address of person who completed cause of death (Item 23a) (Type, Amit Suring MD 7503 Surrate	Print) RD Clinton,	md.	20735	
8	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature  MAR 0 4 2008				